THE HEALTH DIVIDE:

INEQUALITIES IN HEALTH IN THE 1980's

Margaret Whitehead

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PREFACE

This final report from the Health Education Council before its demise on 31 March 1987 is, in my opinion, an essential element in the public debate which must occur on health inequalities in the United Kingdom.

Such inequity is inexcusable in a democratic society which prides itself on being humane. To eliminate or even reduce it substantially would be a major contribution to the health of the people of this country.

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FOREWORD

In 1977 a Working Group was set up by the then Secretary of State for Social Services, David Ennals, to review evidence about differences in health status among the social classes, identify possible causes of those differences and draw implications for policy as well as for further research. At that stage the health of the British population was not improving on some indicators quite as fast as that of a number of other industrial societies. Despite strong support for the National Health Service, and especially for the principle of equal access to health care irrespective of income, on which the service is based, inequalities in health between classes remained disturbingly wide.

Early in 1980 the Working Group submitted its report to the incoming Secretary of State of a new Government, Patrick Jenkin. He published it later that year under a short preface which described the cost of meeting the recommendations in the report as "quite unrealistic in present or any foreseeable economic circumstances, quite apart from any judgment that may be formed of the effectiveness of such expenditure in dealing with the problems identified." Copies of the report were scarce, because few were printed by the DHSS. Nonetheless, the report attracted, and continues to attract, the interest of a large number of doctors and others concerned with health in Britain and many countries overseas.

There seem to be at least two reasons for this interest. One is that an obligation to review patterns of health in a population encourages the objectives and priorities of health care policies to be specified in greater detail and perhaps more plausibly; for example, the standards achieved by some social groups can be properly regarded as attainable by others. A second reason for the interest in the type of review embodied in the Black Report is that an obligation to provide a scientific explanation for inequalities in health is bound to lead to a better definition of responsibilities for a nation's health - especially the balance of responsibilities as between the health care services and other social institutions - like housing, education, industry, agriculture and environmental health. Social and not just individual health has to be defined, measured and explained.

The Working Group found that epidemiological, sociological and medical research had not progressed so far as to allow different material and social elements in the conditions or experiences of individual members of the population to be distinguished and exactly quantified. Indeed, this shortcoming in the capacity to analyse the reasons for the unequal distribution of health in populations represented, and unhappily still represents, a major research challenge for all the sciences concerned with health. A concerted research strategy, aimed at cutting unnecessary premature deaths and rapidly promoting good health, as was recommended, continues to be very urgently required.

However, despite the provisional or general nature of the evidence which was then available, the Working Group under Sir Douglas

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Black found that material deprivation played the major role in explaining the very unfavourable health record of the poorer sections of the population (especially of the partly skilled and unskilled manual groups making up more than a quarter of the entire population), with biological, cultural and personal life-style factors playing a contributory role. This conclusion carried a powerful implication for the construction of policy. The elimination or reduction of material deprivation and not just the organisation of more efficient health care services had to become a national objective for action. Policies external to the National Health Service were therefore of crucial inportance if inequalities were to be reduced and Britain's health performance radically improved. The report also called attention to the fact that insufficient attention was being paid to the need to promote healthier life-styles more equally among the population. There were financial, educational and other restrictions on the opportunities of some groups to achieve better life-styles. This tended to sharpen health inequalities in Britain.

In the seven years since the report was submitted new evidence about mortality and other aspects of health has been published, and a number of the propositions, both scientific and practical, in that report have been examined publicly. Some elements in the discussion - like the relationship between unemployment and health, the renewed concern with housing, the evidence of greater social polarisation, the changes taking place in the diet and life-styles of millions of people if not yet a majority of the population - are of enormous public interest and are important too for any understanding of patterns of health and the choice of health policies.

The World Health Organisation Regional office for Europe has set targets for Health for All by the year 2000 which were endorsed in 1984 by all European member countries. The first of the 38 targets in the programme is equity in health. The target for greater equity is defined as to bring about a reduction of at least 25 per cent in the differences in health status between groups and countries, by improving the health of disadvantageed groups.

For Britain the implication would be to aim, among different operational possibilities, to cut the annual number of deaths among persons under the pensionable ages in the poorer manual groups by some 20,000 from the figure that might be projected from present trends for the last year of the century. If an effective programme were now to be introduced thousands of deaths each year would be saved, building up to the figure of 20,000 in the last year of the century. Another implication of the programme would be to cut the likely number of chronically sick and disabled people under the pensionable ages in the poorer manual groups at the end of the century by approximately 100,000. On the basis of the latest data from the social and medical sciences these kinds of objectives are, in our judgment, attainable.

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As the WHO recognises, the undertaking to reduce health inequalities by at least 25 per cent will remain an empty gesture unless radical steps are taken by Governments to seek better information, undertake large-scale experiments, introduce anti-poverty policies, give priority to healthier life-styles and monitor the effects of those experiments and policies on the health of the population as a whole and on the health of the poorest groups in particular. The Health Education Council's aim to bring the latest data together in a new report is very welcome. It is a major contribution to public knowledge and to the fresh consideration of social inequalities in health in the much larger international and not only national context agreed among nations. We believe that the Health Education Council's review of the up-to-date evidence and of current scientific discussion will provide a valuable stimulus to the public debate which necessarily must take place.

Douglas Black, Jerry Morris, Cyril Smith
and Peter Townsend (March 1987).

(The 4 members of the Research Working Group and authors of 'Inequalities in Health' under the chairmanship of Sir Douglas Black).

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I wish to say a big thank you to the following for giving so generously of their time and expertise: Alex Scott-Samuel, Bobbie Jacobson, Professor Peter Townsend, Professor Jerry Morris, Madeleine Gantley, Patti White, Richard Wilkinson, and Zarrina Kurtz. Without their help this report would not have seen the light of day.

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INEQUALITIES IN HEALTH IN THE 1980's

SUMMARY

1. Background and format

The pattern of health inequalities in Britain was thoroughly documented by the Black Working Party, drawing on evidence from the early 1970's. But what does the picture on inequalities in health look like in the 1980's? How has it changed, and what progress, if any, has been made towards implementing the recommendations of the Working Party?

These questions formed the starting point for the present review, which summarises the evidence on social inequalities in health published since 1980, and draws attention to some of the recent initiatives which have been undertaken in this field. Closely following the format of the original Black Report the review first considers how the experience of health of people living in Britain in the 1980's varies with their occupational class, employment status, gender, area of residence, ethnic origin and housing tenure. It goes on to look at whether the health gap between the occupational classes has widened or narrowed in recent years; whether there are differences in the use and availability of health services for different social groups; and whether international comparisons can offer further insight. New studies investigating the causes of inequalities in health are outlined and discussed. In the final sections responses to the Black Report's recommendations are considered from the research perspective, from the health and social services sector, and from society in general encompassing the actions of local and national government.

2. Health inequalities today

The evidence presented in Section 2 confirms that serious social inequalities in health have persisted into the 1980's. Whether social position is measured by occupational class, or by assets such as house and car-ownership, or by employment status, a similar picture emerges. Those at the bottom of the social scale have much higher death rates than those at the top. This applies at every stage of life from birth, through to adulthood and well into old age.

Neither is it just a few specific conditions which account for these higher death rates. All the major killer diseases now affect the poor more than the rich (and so do most of the less common ones too). The less favoured occupational classes also experience higher rates of chronic sickness and their children tend to have lower birthweight, shorter stature and other indicators suggesting poorer health status.

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The unemployed and their families have considerably worse physical and mental health than those in work. Until recently, however, direct evidence that unemployment caused this poorer health was not available. Now there is substantial evidence of unemployment causing a deterioration in mental health, with improvements observed on re-employment.

The well-established pattern of women having lower death rates than men, but experiencing higher sickness rates still holds true in the 1980's. Recent studies have shown that the situation is far more complex, though. Women's health varies with social class, employment and marital status in ways which are only just beginning to be understood. The health of working class women is particularly poor.

Striking regional disparities in health can still be observed. From 1979-83 data, death rates were highest in Scotland, followed by the North and North West regions of England, and were lowest in the South East of England and East Anglia, confirming the long established North/South gradient. What is becoming increasingly clear from fresh evidence is the great inequalities which exist between communities living side by side in the same region. Numerous studies at the level of local authority wards have pin-pointed pockets of very poor health, corresponding to areas of social and material deprivation. Alongside them, areas with much better health profiles can be detected and these exhibit more affluent characteristics. Although such deprived areas can be found throughout the country, the North has a higher concentration of them than the South and South East.

The health of ethnic minorities shows a varied picture. Strikingly high mortality from hypertension and strokes is found among people of Afro-Caribbean origin and high mortality rates for babies of mothers born in Pakistan. High death rates from accidents for all immigrant groups also causes concern. However, most ethnic minority groups have lower death rates than U.K.-born people from other major diseases like lung cancer and chronic bronchitis.

3. Recent trends

Section 3 considers whether the health inequalities have increased or decreased in recent years. In the decade from 1971 to 1981 there was a fall in all-cause death rates in Britain, but these improvements in health were not experienced equally across the population. Non-manual groups experienced a much greater decline in death rates than manual groups, thus the gap between the two groups widened. Furthermore, death rates among women from coronary heart disease and lung cancer actually rose in manual groups over the 10 year period, while showing a substantial decline for non-manual women. There was also a widening gap between manual and non-manual groups in their rates of chronic sickness from 1974 to 1984.

The more controversial issue of long-term trends is discussed and new assessments of the data reviewed in the Black Report, are

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summarised. The studies confirm the original conclusions of the report: that inequalities in health have widened since the 1950's. The exception to the widening trend is in relation to babies aged one month to one year. There was a dramatic decline in their death rates during the 1970's in all classes, but especially in class V, and thus the mortality gap narrowed considerably. Although there has been very little further improvement since 1980 for manual or non-manual classes the evidence does illustrate that the class differential is not inevitable. It can be reduced.

4. Use of health services

Section 4 considers access to and use of health services by different groups in the community. On the issue of availability of services, there are still examples of poorer provision in more deprived areas and poorer quality, though no overall picture of the extent of inequality around the country is available.

There is general agreement that semi- and un-skilled manual groups still make less use of preventive services than professional and managerial groups, but have higher rates of general practice consultations. Whether the rates of use of the primary care services fully match the different levels of perceived illness within each group is a vital question. Although there have been a few studies in this field since 1980, the evidence on this issue is still inconclusive. Claims that all socio-economic groups have equal access to and opportunity to make use of NHS services are certainly premature.

5. International comparisons

In Section 5 comparisons are made with other developed countries. The U.K. is certainly not alone in experiencing social inequalities in health. Every country to a greater or lesser extent experiences differences in health between regional, occupational or income groups. One of the most important questions for such a comparison is whether any countries have managed to reduce inequalities in the population and if so, how. In this context the Finnish experience of reducing regional differences in health and health care was illuminating. This policy of channelling resources to where they are most needed appears to have paid off.

6. Explaining health inequalities

Explanations of continuing inequalities are considered in Section 6. From the evidence it is concluded that health inequalities between social groups are genuine and cannot be explained away as artefact. There is evidence of some selection, in which those in poor health move down the social scale. However, this is not sufficient to account for the large differentials in health found between social groups. On the other hand, the evidence that socio-economic circumstances have a major impact on health is now extremely strong. Fresh evidence shows that life-style and material living conditions influence health and vary with occupational class. Furthermore, recent in-depth studies have increased understanding of how living and working conditions

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can impose severe restrictions on an individual's ability to choose a healthy life-style. They have provided fresh insight into the way behaviours are influenced by social conditions and argue for a policy which recognises the link between the two, in preference to policies which focus solely on the individual.

7. The Research Response

Sections 7, 8 and 9 deal with progress made on the recommendations of the Black Report. None of the recommendations concerned with improving the collection of information or monitoring social inequalities in health has been adopted. The informtion required to carry out vital research is still not available in many cases. What is even more frustrating is the fact that in recent years the traditional sources of information on social class and health and deprivation and health have also virtually dried up. For example in the past many have relied on the Registrar General's occupational mortality decennial supplements for authoritative information, but the latest supplement (1986) scarcely addresses the issue.

Despite these difficulties, notable advances have been made in the way data are collected. Post-coding of birth and death records, for instance, has made it much easier to carry out small area studies and this field has developed considerably as a result. The development of measures of area social inequality was called for by the Black Report and much progress has been made towards this end. More sensitive ways of measuring social class continue to be explored to supplement the use of occupations. Measures of health are being developed which take more account of the impact on a person's daily life, to supplement traditional measures like mortality and morbidity rates.

8. The Response to Policy Recommendations

Many recommendations in the Report focused on what the health and social services could do to reduce inequalities in health, together with proposals for action in the wider community beyond.

The response to the recommendations has been characterised by a lack of action, particularly at national and central level. No unifying lead has been taken to guide and motivate a response which would have translated recommendations into action.

Some of the services the Working Party wanted to see built up and revitalised have remained at the same level or in some cases may have deteriorated. For example, the child health services, provision of day care for under 5's, and the school health services, which were seen as ways of giving children a better start in life, are all giving cause for concern.

Similarly with services for disabled people, shift in resources towards support for people in their own homes has been minimal. Prevention and health education are still not being given the priority that was recommended.

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In the wider community, the Working Party saw the abolition of child poverty as number one priority for the 1980's. Improvements in housing and working conditions were also recommended, as was a proper mechanism for co-ordinating health-related policy at a national and local level.

In reality what has happened over the past 6 years is a disturbing increase in the number of children growing up in poverty, and an increase in families becoming homeless. Policies deliberately designed to reduce child poverty have not been adopted and the situation has been exacerbated by a sharp rise in the level of unemployment which has affected families with young children in particular.

A concerted effort to improve housing conditions has not been made and there is now growing concern over the shortage of houses and the poor state of repair of existing dwellings. There is no evidence except in isolated cases, that government, employers and trades unions have come together to formulate plans for creating healthier working conditions or to monitor the working environment more effectively.

Mechanisms for co-ordinating policies on health in local and national government have not been set up on a significant scale, even though it is widely acknowledged that health promotion policies need to involve many agencies outside the health sector such as housing, environmental control, transport, food and agriculture and - above all - the Treasury.

Much of this summary so far may have sounded very negative. It would be wrong to give the impression that no-one cares about inequalities in health and no attempts had been made to remedy them. Although a co-ordinated policy has not been set in motion, a great deal has been done by individuals and by organisations in direct response to the Black Report. A selection of the many initiatives is described including health and social service projects to improve the access of deprived communities to primary health care; to explore the community development approach; and to encourage independence in old age, to name a few.

Sections 8 and 9 also note the tremendous efforts made by some health authorities and local government authorities to compile local "Black Reports" and to build up health data bases as well as to work out health strategies. Initiatives by a number of major employers and trades unions to bring health promotion and disease prevention into the workplace are also noted.

In addition the paper highlights the work of many professional bodies and organisations concerned about inequalities. Some have formulated policy and plans for tackling the problem of health inequalities from their own particular perspectives. Together, these initiatives are helping to keep the issue of health inequalities firmly on the agenda.

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SECTION 1

INTRODUCTION

1.1 Aims

In 1980 the Working Party on Inequalities in Health chaired by Sir Douglas Black produced an authoritative report documenting health inequalities in Britain.(1) Immediately it stimulated a widespread response from the research community, and since then much more evidence has accumulated on several different fronts.

It is not easy for the non-specialist to keep abreast of all the developments. Additionally there is a growing desire to know what the picture of inequalities in health looks like in the 1980's, as the Black Report drew much of its data from the early 1970's. The main aims of this review, therefore, are to draw together and summarise this wide-ranging new evidence; to provide an insight into the literature; and to act as a resource for those working in diverse fields who share a common interest in the issue.

As it is intended as an update rather than a long-term perspective, generally speaking only research published since 1980 has been cited. For the evidence on earlier work the reader is referred to the original Black Report of 1980(1), or to the more widely available Penguin version of 1982.(2)

1.2 What is meant by inequality?

It is widely accepted that there are natural inequalities in health in the population - human beings vary in health as they do in every other aspect of life. What is being assessed in this report is the extent of unfair or unacceptable inequalities: what some would call "inequities". Deciding what is fair and just comes down to a subjective judgement in the end, but many would probably agree with the comments on social justice expressed at a World Health Organisation meeting:

> In health care the principle of social justice "leads to equal access to available care, equal treatment for equal cases and equal quality of care."(3)
>
> In health terms, "ideally, everyone should have the same opportunity to attain the highest level of health and, more pragmatically, none should be unduly disadvantaged."(3)

There are two schools of thought about where the root of the problem of inequality lies. Some would see inequality solely in terms of a distinct deprived group, separate from the mainstream of society, in need of special policies and resources to bring them up to the standard of the rest of the population.

Others would say that what happens in the whole of society has a bearing on inequality. For instance, poverty cannot be considered without considering wealth, or unemployment without employment, and

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the effect that each has on the other. In this case, studies and policies would not be restricted to the most disadvantaged, but would be wide-ranging and encompass the whole of society.

In an attempt to give a broad overview, this paper has not been limited to a consideration of deprivation and ill-health, but has included examples of studies from both schools of thought.

Whatever the merits of the two theoretical approaches, there has been a major policy development in this field in the 1980's. In 1980, the U.K. committed itself to a common health policy together with the other 33 members of the European Region of the World Health Organisation, entitled "Health for all by the year 2000".(4) In 1984, targets were agreed for the strategy, the first of which was:

> "By the year 2000, the actual difference in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups."(5)

So, the aim of reducing inequality in health in this country is now official policy which must surely be seen as a major step forward.

1.3 Concepts of health and health indicators

Work by WHO in clarifying the meaning of health and health promotion for practical policy-making purposes, has moved forward since 1980.(6) Health is taken to encompass physical, social and emotional well-being and is increasingly seen in terms of a positive resource for life, rather than the objective of living.(7,8)

Defined in these positive terms, it is recognised that ideally strategies designed to promote health should go beyond the health services, to encompass legal, fiscal, educational and social measures in an integrated approach. In practice, the development of ways of measuring health has not kept pace with theory.(9)

Traditional measures predominate, concentrating mainly on physical, and to a certain extent mental ill-health, by the use of mortality and morbidity statistics. However, the 1980's have seen concerted efforts to develop and use 'quality of life' measures like the Nottingham Health Profile, which provides a subjective indicator of the experience of illness in the community - the physical, social and emotional effects experienced by the individual.(10) More use has also been made of measures like the General Health Questionnaire to assess minor psychiatric illness in the community.(11) Several studies in Section 2 use such measures, and the techniques employed are described in greater detail in Section 7. These new measures are intended to complement rather than replace traditional indicators.

Mortality and sickness rates are still used in this report to described health status, though more positive indicators are introduced wherever possible.

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1.4 Social indicators

Occupational class, used extensively in this report, is still the most widely used indicator of the social circumstances of different groups in society, but it is now being supplemented by information from other measures, like the Social Index.[12] In addition it is now much easier to use the census data and health data in a more constructive way, to explore other measures of inequality like car-ownership, housing tenure, employment, status of residential area, and housing conditions. A variety of social and material deprivation indicators have been devised as a result. These have been used, particuarly in the small area analyses described in Section 2. The details and merits of some of the major ones are discussed in Section 7.

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SECTION 2

HEALTH INEQUALITIES TODAY

2. In this section the present pattern of social inequalities in health in Britain is outlined. It looks in turn at how the experience of health of people varies with their occupational class, housing tenure, employment status, gender, area of residence and ethnic origin. How this pattern compares with previous decades is considered in Section 3, and more specific research into the causes of inequalities can be found in Section 6.

Reviews which give excellent insight into the issues discussed in Section 2, include Townsend and Davidson (introduction) 1982[2], Macintyre (1986)[13] and Blaxter (1986)[14]

2.1 Occupational class and health

Studies quoted below show that the risk of death for lower occupational classes in the 1980's was much higher than that of the highest occupational classes at every stage of life. Thus stillbirths, deaths under one, deaths in adults of working age, and deaths in old age show this gradient from lower mortality in the richer classes to higher mortality in the poorer classes. The evidence presented also shows that it is not just one or two specific causes of death which are to blame for the higher mortality, but the full range of deseases with very few exceptions are affecting the poorer classes more than the rich. Only a wide ranging general explanation could account for such a phenomenon. In addition examples are given from the growing body of evidence showing that lower occupational classes experience much more illness and a poorer quality of self-perceived health during their lives.

2.1.1 Recent Evidence

The Registrar General's scale of five social or occupational classes, based on the occupation of the head of the household, has been widely used to distinguish groups who share a common way of life and level of prosperity (see page 83 for its limitations and alternatives).

The five classes consist of the following:

Class I	-	professional	- eg lawyer, doctor, accountant
Class II	-	intermediate	- eg teacher, nurse, manager
Class III N	-	skilled non-manual	- eg typist, shop assistant
Class III			
Class III M	-	skilled manual	- eg miner, busdriver, cook
Class IV	-	partly skilled manual	- eg farmworker, bus-conductor, packer
Class V	-	unskilled manual	- eg cleaner, labourer

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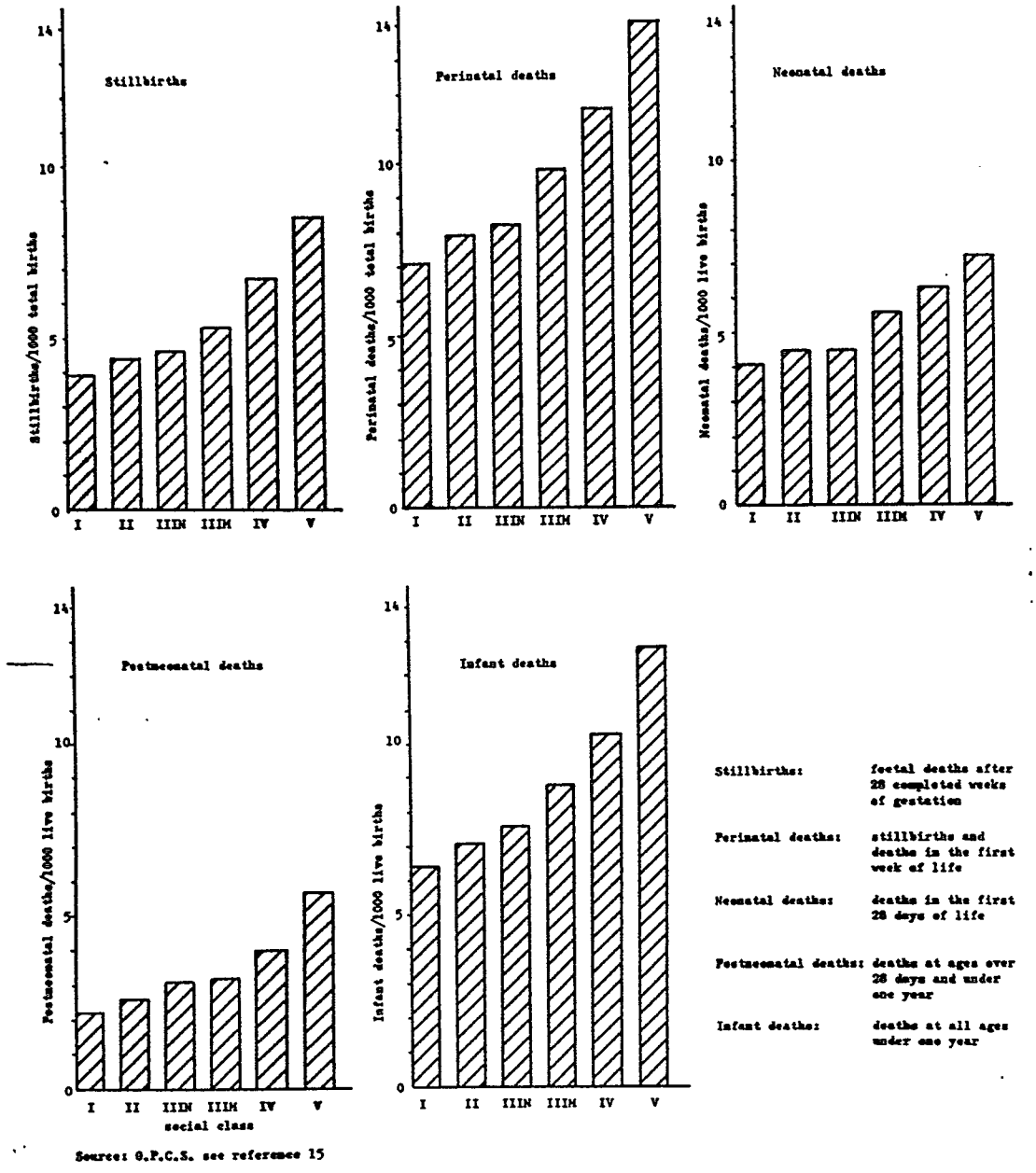
Using this scale, clear evidence emerges of occupational class differences in mortality in the early 1980's.

Figure 1

Outcome of pregnancy by social class of father. England and Wales, 1984



Source: O.P.C.S. see reference 15

Figure 1 illustrates the typical pattern found in early life. In 1984(15) rates of stillbirth and death at various stages in the first year of life increased progressively from occupational class I to class V. Thus babies whose fathers had unskilled jobs ran approximately twice the risk of stillbirth and death under one year, than babies whose fathers worked in the professions.

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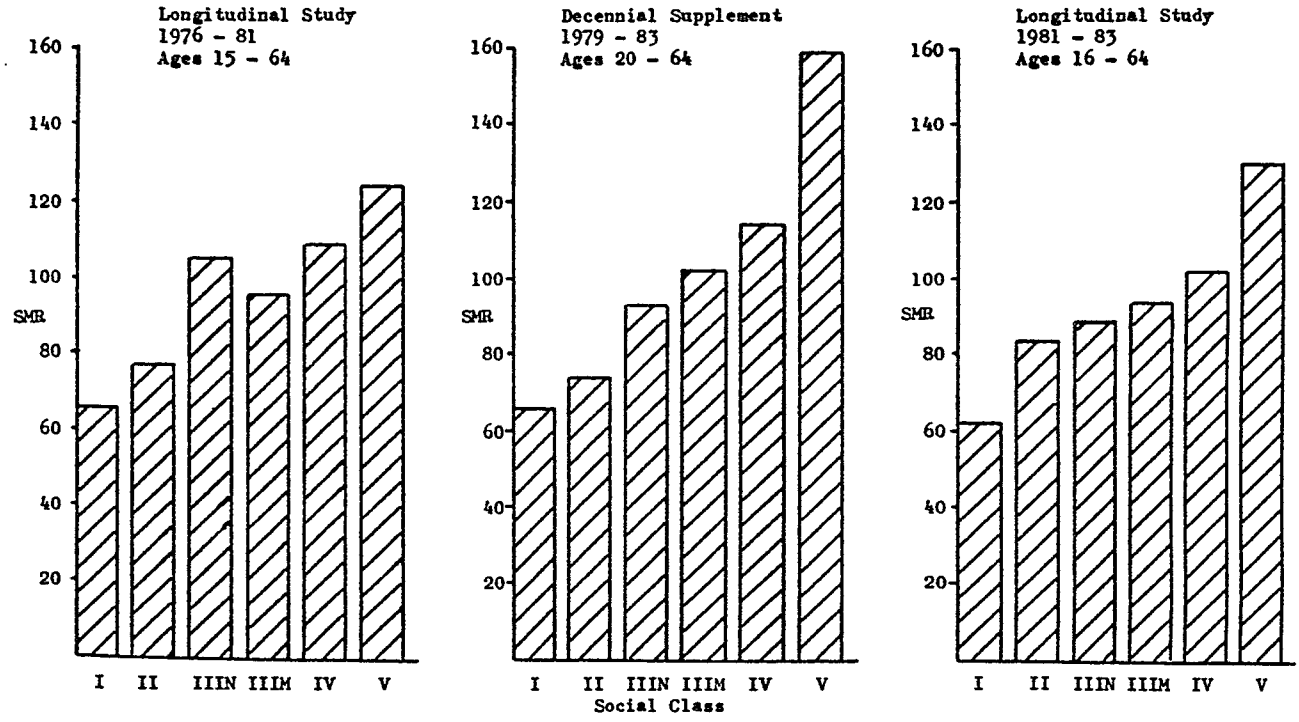
Up-to-date statistics on occupational class differences in the death rates of older children will be published by OPCS in April 1987[16], and these are awaited with great interest as wide differences in health could be seen from the 1970-72 data on this age range.

Evidence of a distinct gradient in death rates in adults of working age is available from two major national sources: the Decennial Supplement for 1979-80, 82-83[17] and the OPCS Longtudinal Study[18] covering 1976-81 and 1981-83. Figures 2 and 3 illustrate the data from both sources using standardised mortality ratios (SMR).

Figure 2

Mortality of men of working ages by social class in England and Wales, 1976-81, 1979-83, 1981-83



Source: Drawn from O.P.C.S. data see ref 17 and 19

Note that the Decennial Supplement[17] records a very high SMR for class V. For technical reasons, related to the re-classification of occupations by the Registrar General in 1980, it is thought that class V figures may be artificially raised and the lower Longitudinal Study figure may be more reliable.[17]

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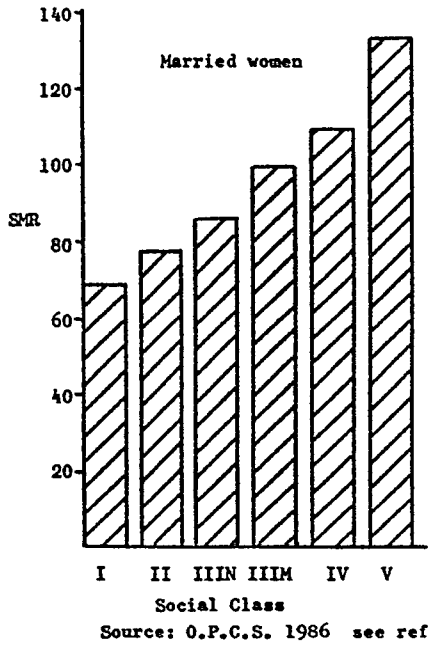
Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Figure 3

Mortality of women aged 20 - 59 by social class in Great Britain, 1979 - 83



Source: O.P.C.S. 1986 see ref 17

Footnote: the Standardised Mortality Ratio (SMR) is the ratio of the mortality rate in a particular occupational class compared to the average for the whole population, after allowing for the difference between their age structure. The SMR for all men or all women would be 100. SMRs below 100 indicate lower than average death rates. SMRs above 100 indicate higher than average. The data for the early 1980's show a step-wise increase in death rates from low levels in Class I to high levels in Class V. Unskilled workers run at least twice the risk of death as professionals.

The mass of information on social class and mortality contained in the Decennial Supplement (D.S.) can still be used by grouping all the manual classes together and comparing them with all the non-manual classes.[20] Alternatively data on class I and II can be combined and then compared with data on combined classes IV and V to compare the health of the richest and poorest classes.[21] Analyses of this nature have already begun. For example, using the Decennial Supplement data, Marmot and McDowall (1986)[20] have carried out a careful study of some of the major causes of death

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

for men and married women in the two distinct categories: manual and non-manual. Table 1 shows the results of the study. For all the causes analysed, non-manual workers in 1979-83 had lower SMRs than manual workers. It was particularly striking in the younger age range. Married women showed a similar pattern.

Table 1 - SMRs* FOR SELECT CAUSES OF DEATH IN GREAT BRITAIN 1970-72 AND 1979/83 AMONG MEN AGED 20-54 AND 55-64

Cause of death	Age	1970-72			1979/83		
		Non-manual	Manual	NM/M	Non-manual	Manual	NM/M
All causes	20-54	98	131	0.75	76	115	0.66
	55-64	99	128	0.77	82	117	0.70
	20-64	99	129	0.77	80	116	0.69
Lung cancer	20-54	93	167	0.56	60	133	0.45
	55-64	85	145	0.59	67	128	0.52
	20-64	87	150	0.58	65	129	0.50
Coronary heart disease	20-54	103	120	0.86	80	113	0.71
	55-64	102	110	0.93	90	117	0.77
	20-64	102	113	0.90	87	114	0.76
Cerebro-vascular disease	20-54	107	141	0.76	73	121	0.60
	55-64	123	151	0.81	77	119	0.65
	20-64	118	148	0.80	76	120	0.63

* For each cause, and within each age group, the SMR for all men in 1979/83 is 100. The 1970-72 figures were standardised with the 1979/83 rates.

Source : Marmot and McDowall, The Lancet (1986) See Ref. 20.

Townsend et al[21] have also analysed the D.S. data by cause of death, comparing the two highest and the two lowest occupational classes. The work illustrates that all the major killer diseases now affect the poorest occupational classes more than the rich. In 65 of the 78 disease categories for men SMRs for classes IV and V were higher than for either class I or class II. Only one cause, malignant melanoma, showed the reverse trend. For women 62 of the 82 categories of disease showed higher SMRs for classes IV and V and only 4 showed the reverse. The rest were neutral.[21] Clearly so called "diseases of affluence" have all but disappeared and what is left is a general health disadvantage of the poor.

Two major longitudinal studies have also shed light on the situation since the publication of the Black Report: the OPCS Longitudinal Study (LS)[18,22] and the Whitehall Study of civil servants.[23,24]

The OPCS Longitudinal Study selected a 1% sample of the population of England and Wales from the 1971 census and has continued to follow vital events in the sample and their associated families by use of flagged birth, death and cancer registrations. The study has been able to look at mortality in 1976 - 81 by occupational class in broad age groups.[18] Figure 4 shows that even in ages after retirement the mortality gradients for men are almost as steep as those found in the later stages of working life. Thus, even in old age, men from occupational class V had more than 50% higher death rates than those in occupational class I. Fox et al (1986)[18] point out that these are "The first reliable estimates of the social class gradient in England and Wales at these older ages." The study is currently analysing the data with respect to women.

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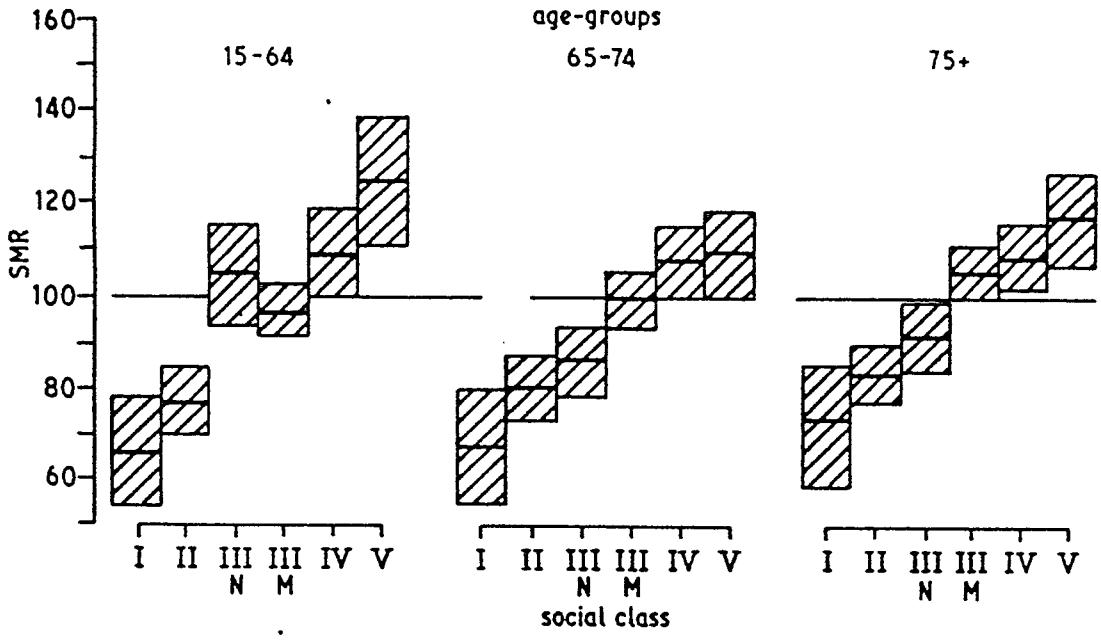
Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Fig. 4

Mortality of men in 1976–81 by social class and broad age groups



Source: O.P.C.S. Longitudinal Study Fox et al see ref. 18

The Whitehall study of civil servants examined over 17,000 office-based civil servants in London in 1967-69 and has been following the health of the men in different grades of the service for more than a decade now. The study has found that the lower the grade, the higher the mortality for every cause of death except genito-urinary disease. There is a greater than three-fold difference between the highest and the lowest grade: a much steeper gradient than the occupational class gradient found in the national data.[23,24]

Other studies of single occupations have also found steeper gradients. For example, Lynch and Oelman (1981),[25] looking at mortality from coronary heart disease in different ranks in the British Army in 1973-77 found increasing mortality with decreasing rank with a five-fold difference between highest and lowest rank.

It seems that the national gradients may underestimate the real differences between social groups, because each class is made up of occupations with a range of mortality rates. Studies on single occupations are more homogeneous and can reveal a sharper distinction between top and bottom groups.

Not only do lower occupational classes have higher death rates, but they also experience more sickness and ill-health throughout their lives. Indeed Blaxter (1986)[26] argues that morbidity or general health status are more important indicators of inequality now that people are living longer and degenerative disease is becoming more prominent. One of the main sources of information

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

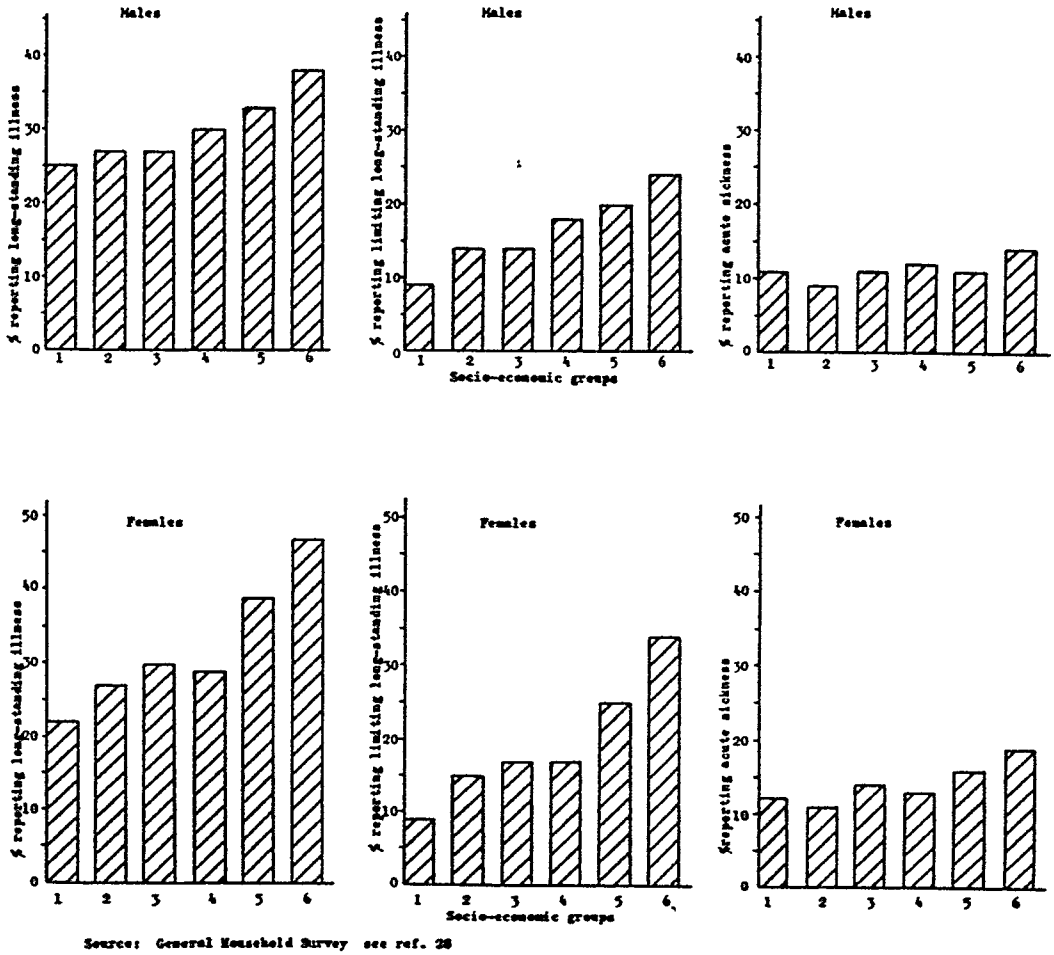
on morbidity is the annual General Household Survey[27] in which people are asked about both chronic and acute sickness. For such purposes six socio-economic groups are used, which correspond fairly well to the Registial General's scale. The six socio-economic groups are:

1. professional
2. employers and managers
3. intermediate and junior non-manual
4. skilled manual
5. semi-skilled manual and personal service
6. unskilled manual

Rates of sickness have remained relatively stable since 1980. Figure 5 shows the rates for 1984 for each socio-economic group and reveals great inequalities between the groups[28]. The gradient is steepest for limiting long-standing illness, where the rates in the unskilled manual group are more than double those of the professional group for both men and women. The gradient is not quite as steep, but still marked for long-standing illness without limitation; while for acute sickness the differential is only evident at ages over 45.

Figure 5

Percentage of population reporting chronic and acute sickness by sex and socio-economic group. 1984



Source: General Household Survey see ref. 28

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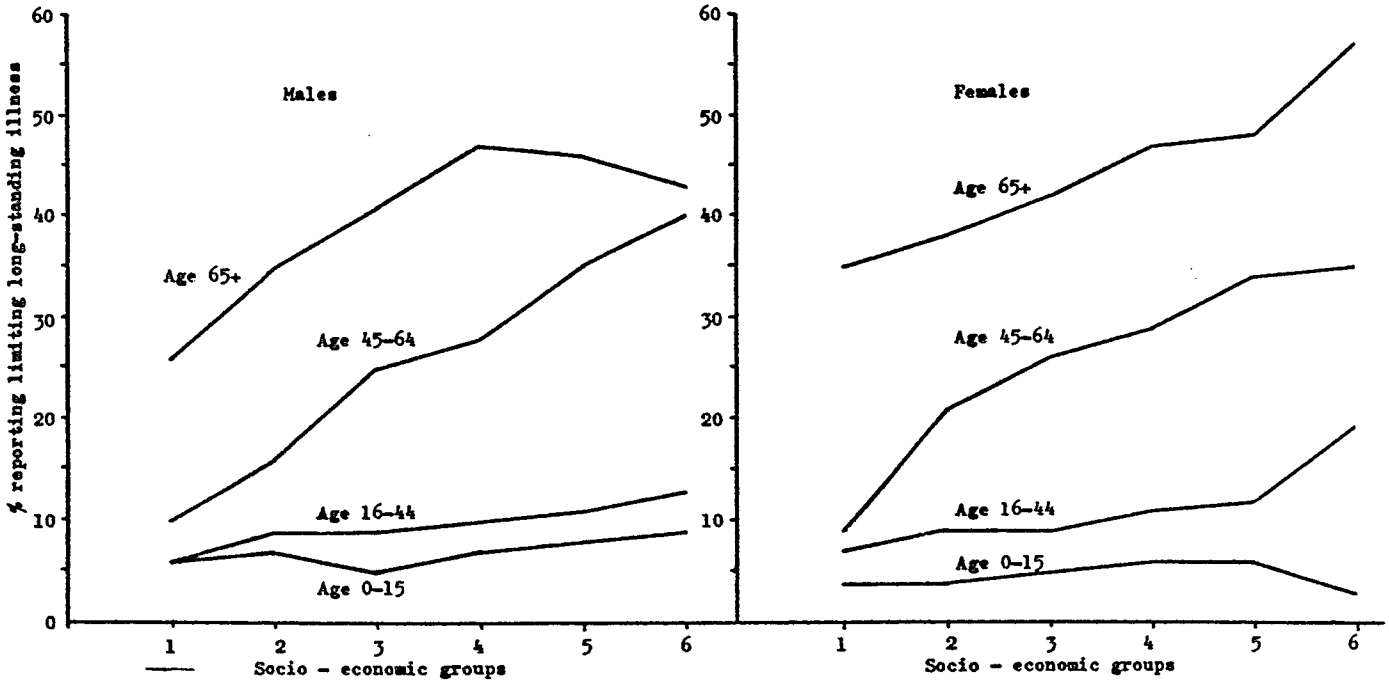
Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

When age as well as socio-economic group is taken into consideration it is in middle-age that the differences between the socio-economic groups are greatest. See Figure 6.

Figure 6

Percentage of population reporting limiting long-standing illness by age and socio-economic group in 1984.



Source: General Household Survey see ref. 28

From similar data, Blaxter[26] concludes that health deteriorates more rapidly in those who are socially disadvantaged. She quotes Ferge et al[29] as saying:

> "sicknesses appear in the case of the majority sooner or later, but the worse off you are the sooner it hits".[29]

Following the publication of the Black Report, Burchell (1981)[30] re-examined data from the 1976 General Household Survey to identify the main factors influencing the presence/absence of long-standing illness in adults. Age and sex were found to be the most important factors. Controlling for these he confirmed the conclusions drawn by the Black Working Party: that the rates of long-standing illness rose with falling socio-economic status. As a number of other variables like smoking behaviour, education, marital status and overcrowding factors were also relevant, he suggested that occupational class may be acting as a proxy for a more complex combination of these variables.

Unfortunately, the General Household Survey data give no insight into the nature of the reported illnesses. During the 1980's a number of surveys have used the Nottingham Health Profile to study differences in self-perceived health and its impact on daily lives. The nature of ill-health is considered under six main headings:

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

lack of energy, pain, sleep disturbance, physical immobility, emotional distress and social isolation. Using the profile Hunt et al (1985)[31] in a survey in 1981 found clear differences in perceived health problems between occupational classes, but only in the 20-44 age group: the lower the occupational class the greater the amount and severity of perceived distress. For example, men from classes IV and V scored twice as high as men in classes I and II on the sections measuring lack of energy and emotional distress, over 3 times as high on the section measuring sleep disturbances, and over 4 times as high concerning feelings of social isolation. For women the findings were similar, though less marked. After the age of 45 the differences were smaller.

Most recently Bucquet and Curtis (1986)[32] used the Nottingham Health Profile to collect data on a sample of local residents in three London Boroughs; dividing the sample into manual and non-manual classes. The manual groups registered higher rates of tiredness, sleep problems, pain and emotional distress, in line with the findings of Hunt (1985).[31]

In a pilot study of several different measures of health, Blaxter[33] found that manual groups not only had higher rates of chronic disease and disability than non-manual groups, but also were more likely to register a lack of psychological well-being and to have poorer fitness scores.

An important new national study, the Health and Lifestyle Survey[34], has been investigating other dimensions of health and well-being. The study is unusual in using physiological measurements, like blood pressure and lung function, in addition to in-depth interview techniques and in using income as well as other measures of social disadvantage. Preliminary results have revealed large gradients by social class in a number of conditions like arthritis, haemorrhoids and deafness which can have a considerable effect on the quality of life within threatening life. Differences in self-reported health by income were also found. For instance those with lower incomes tended to report higher rates of illness symptoms and define their own health as poor, compared to their richer counterparts.[14]

Most of the above studies were based on self-reported health but there are numerous studies based on objective medical and dental observations which confirm the overall piture. For example OPCS data for 1984[15] showed that low birthweight was still much more common in babies born into lower occupational class families. (Low birthweight is considered to be the single most powerful predictor of death in the first month of life.[36])

In contrast, in the 1980 national survey of heights and weights,[37] childhood and adult obesity was a problem more common in men in class III manual and women in classes IV and V. This was supported by a cohort study of children born in 1946. By 1982 (when the sample was 36 years old) higher rates of obesity were found in lower social groups in both men and women.[38]

Height which can be taken as an indicator of general health, varies with occupational class. The 1980 survey[37] found that in almost every age group people from manual class households were

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

shorter on average than people from non-manual class households. Marmot, Shipley and Rose (1984)[24] found that height was significantly related to grade in the civil service. For example, the administrators (highest grade) were on average 4.7 cm. taller than men in the "other" grades (lowest grade).

In the same study, men in lower grades in the civil service had higher blood pressure and lower levels of glucose tolerance than the top grades.

Leon and Wilkinson (1986)[39] examined the survival rates from cancer and coronary heart disease in men and women from the O.P.C.S. Longitudinal Study. They concluded that lower class people with cancer had poorer survival prospects.

The adult dental health survey of 1978[40] found that the proportion of people from class I with no natural teeth was much lower than in the other classes, though class IV and V had shown a marked improvement over the previous decade.

The OPCS survey of children's dental health in 1983[41] found poorer health in lower occupational classes on several counts. For example, amoung 5 year olds on average twice as many teeth were actively decayed among those from the manual classes compared to the non-manual classes. They also had more teeth missing due to decay.

2.2 Housing tenure and health

Occupational class has been used so extensively as a social indicator because it is convenient and relatively simple to collect information on occupation. But other measures based on assets, like housing tenure and car-ownership are increasingly being used to investigate the association between poverty and ill-health. They are used as indirect indicators of wealth and command over resouces.[2]

There are persistent differences in mortality and morbidity between tenure groups. For example higher stillbirth and infant mortality rates have been found in babies born to private tenants compared to owner-occupiers.[42] The OPCS Longitudinal Study found higher mortality rates for local authority tenants, than for owner-occupiers.

The study has also been able to look at housing tenure and mortality in different types of local authority ward. 36 distinct ward types have been identified in England and Wales from previous census studies[43,44] ranging from residential retirement areas to new towns and inner city areas. In 35 of the 36 types of ward owner-occupiers had lower SMRs than local authority tenants[45] Table 2 gives the evidence on 4 different types of "clusters" or wards.

Table 2 illustrates that in all four types of area the owner-occupiers had lower mortality ratios than private tenants who in turn had lower mortality ratios than the local authority housing tenants. It also illustrates that in each tenure category there was quite a large variation in death rates in different areas,

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Table 2 Mortality in 1971-1981 of males in selected clusters in 1971, by housing tenure in 1971.

Cluster*	Housing tenure					
	Owner occupied		Privately rented		Local authority	
	Deaths: Observed Expected†	SMR	Deaths: Observed Expected†	SMR	Deaths: Observed Expected†	SMR
35: Residential retirement areas	916 1097.1	83	182 188.1	97	92 88.1	104
1: New towns	188 239.9	78	52 67.0	78	429 383.2	112
9: Older industrial settlements with low stress	1000 1060.1	94	322 279.7	115	488 409.9	119
11: Inner areas with low-quality, older housing	208 186.0	112	357 261.1	137	164 122.8	134

* Craig-Weber
† Expected on the basis of death rates in 1971-1981 in 5-year age groups for all males in the LS 1971 Census sample

Source: Fox et al (1984) see ref. 45

e.g. owner-occupiers in residential retirement areas had much lower mortality ratios than owner-occupiers in inner-city areas. Differences in mortality by housing tenure were wider than differences in mortality by occupational class, and tenure was considered a powerful indicator of the risk of death.(45)

The study was also able to investigate how death rates varied with ownership of a car. High mortality (particularly in men) was recorded for people with no access to a car, and low mortality in households with access to one or more cars.(22)

Such studies all point in the same direction and indicate that however poverty or social disadvantage is measured the link with ill-health is clear and consistent.

Evidence on housing conditions can be found in section 6 page 69.

2.3 Employed or unemployed: the health difference

Unemployment is another factor which has been used as a general indicator of poverty.(21) The following reviews cover in detail various aspects of unemployment and health: Jahoda 1979(46) (historical perspective); Smith 1986 and 1987(47,48) (evidence and health policy); Unemployment and Health Study Group 1986(49) (covers policy and the problems of interpreting research); Platt 1985(50) (suicide and attempted suicide); Warr 1984(51) (mental health); Macfarlane and Cole 1984(52) (mothers' and babies' health).

As in previous decades, the unemployed in the 1980's tend to have much poorer health than those in work, and areas of the country with high levels of unemployment have worse health records than areas with low levels of unemployment. For example, high death

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

rates for unemployed men have been recorded in various recent studies including the British Regional Heart Study of 1978-80[53] and the OPCS Longitudinal Study,[54] which found particularly high levels of lung cancer and suicide.

Many studies have confirmed this association between suicide (or attempted suicide) and unemployment. For instance Kreitman and Platt (1984)[55,56] found that in each year since 1977 the unemployment rate in Great Britain had been positively and significantly correlated with the total suicide rate. A study in Edinburgh during 1978-82 found that the unemployed had a much greater risk of attempted suicide than employed men; of the order of 11:1.[57] The risk ratio increased sharply with the length of the spell of unemployment as follows:

duration of unemployment (men)	ratio of risk of attempted suicide of unemployed to the employed
less than 6 months	6:1
6-12 months	10:1
over 12 months	19:1

Hawton and Rose (1986),[58] in a study in Oxford in 1979-82, found that the attempted suicide rates for unemployed men were 12 to 15 times higher than those for employed men, and again were particularly high for the long-term unemployed. Brenner's[59,60] studies of national economies and national health statistics, have also shown consistent correlations between indicators of recession and mortality in several countries.

The unemployed experience higher levels of illness too. For example in the General Household Survey of 1984[28] 28% of unemployed men reported long-standing illness compared to 25% of working men. Similarly, 29% of unemployed women compare to 25% of working women had some long-standing illness. For women there is the added dimension of the housewife role. Arber[61] found that women classified as housewives had even higher rates of limiting long-standing illness than those who were classified as unemployed (see Arber et al[61] for full description).

Poorer health and development have also been found in the children of the unemployed. Using data from the 1981 census Maclure and Stewart (1984)[62] found that children living in deprived districts of Glasgow were 9 times more likely to be admitted to hospital than children in non-deprived districts. Overcrowding and parental unemployment were the aspects of deprivation most strongly correlated with hospital admission rates. A study of births in the Greater Dublin area found a higher incidence of low birthweight in babies with unemployed fathers than in those whose fathers were employed.[63] The National Survey of Health and Growth found that children with unemployed fathers, especially the long-term unemployed, tended to be shorter than those with employed fathers.[64]

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

In the face of such abundant evidence of inequality the problems of interpretation need to be borne in mind. Are people who are in poor health more likely to become unemployed, or does the experience of unemployment itself have an adverse effect on health? Is it unemployment or an associated factor which causes areas of high unemployment to have high mortality and morbidity rates? Is the poor health experienced by a nation in times of recession a result solely of unemployment or is it also the result of deteriorating safety standards and increased stress on those in work?(65) Separating the effect of unemployment from these other factors has been difficult. Some recent studies however, show promise in disentangling cause and effect.

For example, the British Regional Heart Study of 1978-80(53) investigated in particular cardiovascular disease in middle-aged men selected at random from general practices in 24 towns. The unemployed sample was sub-divided into those who said they were unemployed because of ill-health, (the "ill-unemployed"), and those who considered that their unemployment was not due to illness (the "not-illunemployed"). They found that the frequencies of bronchitis, obstructive lung disease and ischaemic heart disease were indeed higher in the "ill-unemployed" than in the employed group. Th rates of ischaemic heart disease were also significantly higher in the "not-ill unemployed" compared to the employed population. Although smoking and heavy drinking were more common among the unemployed, once adjustments to the data had been made to allow for social class and town of residence, only smoking was slightly higher among the unemployed. Overall they concluded that the ischaemic heart disease rate was significantly higher in the "not-ill unemployed" than the employed, when standardised for age, social class, town of residence, and cigarette smoking. However, this evidence was subject to the limitations of cross-sectional research, and a longitudinal follow-up is underway.

The OPCS Longitudinal Study has been following a sample of men who were "seeking work" at the time of the 1971 census and their mortality was recorded over the next 10 years.(54) As mentioned previously the study found that these men had high mortality rates (SMR of 136) compared to that of all men in the study (SMR of 100). Some of the excess was "explained" by occupational class factors, as unemployment was concentrated heavily in classes IV and V. However, when adjustments were made to control for occupational class, it still left a 21% excess in mortality unexplained. Two factors argue against any suggestion that these men became unemployed simply because they were already unhealthy. Moser et al(54) point out that those labelled as "seeking work" in 1971 would be selected for good health, since there were two "sickness" categories in the census to describe those not working due to poorer health. Also women whose husbands were "seeking work" were found to have raised mortality rates too, (SMR's of 120 when compared to the SMR's of all married women in private households), suggesting a real effect of unemployment on families.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

The latest preliminary results of the Longitudinal Study, relating to men who were seeking work in 1981, follow a similar pattern.[66] The high death rates of men seeking work in 1981 could not be explained by the state of their health or social class before unemployment. Taken together the results lend support to the argument that unemployment had a genuine effect on the mortality rates.

The evidence that unemployment causes a deterioration in mental health is extremely strong. Several studies of people moving in and out of work have shown a decline in mental health on becoming unemployed and an improvement following re-employment. Warr[51,67] has conducted numerous studies of minor psychiatric illness using the General Health Questionnaire and found significant improvements in mental health when the unemployed found work again.

Banks and Jackson[68] in 1982 also used the General Health Questionnaire to assess young people moving from employment to unemployment or vice-versa. They were able to test the young people before they left school and at intervals afterwards. Psychiatric symptoms increased significantly in those who left school and became unemployed and decreased in those who found work. As there had been no significant difference in mental health between the two groups while they were still at school, this is the clearest evidence yet of unemployment being the cause of poorer health.

In contrast, the DHSS Cohort Study of unemployed men[69,70] could find no evidence of a deterioration in self-reported health with unemployment, using the rather simple question "has your health got better, got worse, or stayed about the same since registration?"

Studies which have adopted an in-depth case-study approach have been able to document the effect of unemployment on family life and show that wives and children of unemployed men can also suffer psychologically. See for instance Fagin's study of 20 two-parent families in 1979.[71,72]

In a study based on one general practice in England, Beale and Nethercott[73,74,75] have been tracing the health of workers from a meat-product factory over the course of 8 years. They found a significant increase in G.P. consultation rates and out-patient referrals when the workers were made redundant, while a control group in stable employment in neighbouring factories showed no such increase. Furthermore the decline in health was evident 2 years prior to job loss, dating from the time when the threat of redundancy became apparent. The results suggested that the threat of redundancy was a stress equal to the actual event.

To sum up, the unemployed population continues to have poorer health than those in work. Studies in Britain since 1980 have provided firm evidence that unemployment can cause a deterioration in mental health. The evidence that unemployment causes physical ill-health and suicide is less conclusive, though the OPCS Longitudinal Study provides evidence of excess mortality in the

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

unemployed which cannot easily be explained away.

2.4 Sex differences in mortality and morbidity

The renewed interest in sex differences in health is not purely academic. The question is whether any of the recorded differences are environmentally determined and if so whether there is scope for improvement in health in either sex.

Life expectancy estimates show that in 1981 new born girls could expect to live 6.4 years longer than new born boys, to 76.2 and 69.8 years respectively.(76) While both sexes have improved their chances of living longer (by one year) since 1971, the gap between men and women has widened marginally.

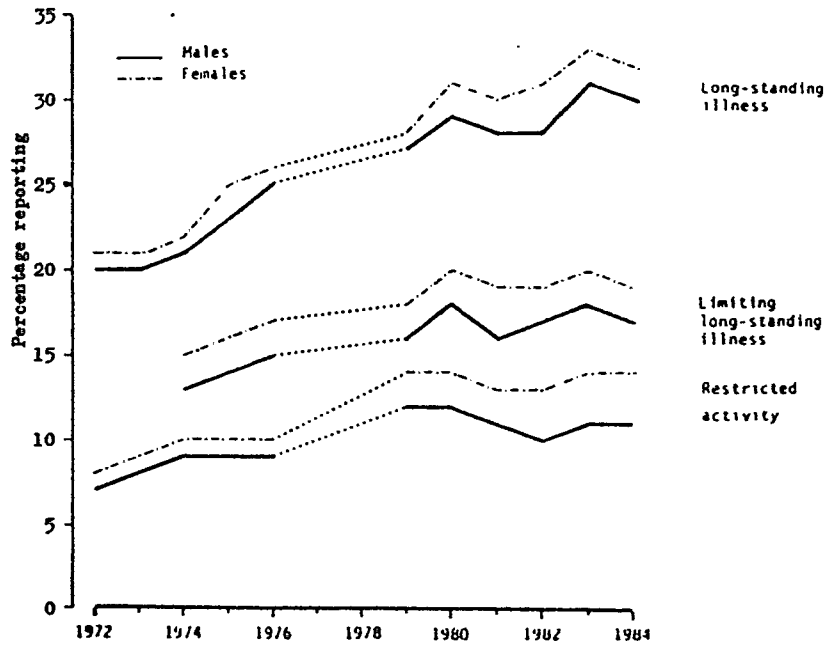
There are higher levels of male deaths in every age group from birth right through to adulthood,(77) when the adult ratio of male to female deaths is 2 : 1.

The causes of death also vary between men and women and for different age groups. One striking difference in young people is in accidental deaths. In 1985 in England and Wales, 40% of deaths in boys aged 1-14 were due to accidents and violence compared to 26% of deaths in girls.(78) By middle age circulatory disease had assumed prominence for men while cancer claimed a high proportion of lives in women.

In general the pattern of differences in morbidity is reversed. Overall, women consistently record higher levels of chronic and acute sickness, as illustrated by Figure 7.

Figure 7

Percentage of males and females reporting (a) long-standing illness (b) limiting long-standing illness (c) restricted activity in the 14 days before interview 1972-1984*, Great Britain



* Data not available for 1977 and 1978

Source: General Household Survey for 1984 see ref. 28

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

The picture is not quite so simple though when each age group is considered separately. For instance in 1983 31% of males and 33% of females reported a long-standing illness. Between the ages of 5 and 15, boys were significantly more likely to suffer a long-standing illness than girls, while at 65 years and over, women were more likely than men to report an illness.(79) In the middle years, there was no significant difference. The higher rates for males in childhood also hold true for rates of limiting long-standing illness and for acute sickness.(79)

The National Survey of Health and Development found that serious illness at 21-25 years old was significantly more common in young men (15.8%) than in young women (11.8%) and the relationship held within each social class.(80)

Studies of mental illness consistently show much higher levels in women than in men.(81) The difficulty of interpreting the data has been reviewed by Briscoe 1982(82) and Clarke 1983.(83) The debate centres on whether the figures reflect real differences in health or are socially determined e.g. due to differences between the sexes in willingness to report illness or to take care of their own health. Attempts have been made to measure psychological well-being. For example in a pilot study in 1985 Blaxter(33) found that men showed a steady decline in well-being with age but for women well-being was lower in young women under 30 and in older women over 70, but was much improved in the years between 50 and 59.

In the last few years, more attempts have been made to look beyond the general finding that men have higher mortality and women have higher morbidity. Studies have begun to investigate how gender inter-relates with occupational class, employment status, marital status and so on. The pattern of health inequality has been mapped much more extensively for men than for women. Studies which have looked at social class differences in women have found striking inequalities in health under certain conditions(84). The subject has been carefully reviewed by Arber (1986)(84). In particular working class women living in urban areas run a very high risk of depression. There is a three fold difference between the rates for working class and professional women.(35)

Haavio-Mannila,(85) commenting on the international literature, points out that marital status and employment are linked to illness among men and women. Mental health is best among married men, followed by single men and women, with most psychiatric problems found in married women. However, employed married women report less physical and mental illness than housebound women. The complex relationship between paid employment and women's health is reviewed by Arber et al(61).

Trends in the sex diffential are discussed in section 3 and the possible explanations for these observed differences are discussed in Section 6.

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2.5 Regional Differences

The Black Report commented on differences in mortality between the major regions of the U.K., with mortality rates increasing from South and South East to North and North West of the country.

Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

These regional differences have persisted into the 1980's as illustrated in Table 3.

Table 3

Mortality of Men and Women in Different Regions of Britain, 1979-80 plus 1982-83

Region	Direct age-standardised death rate (per 1000)		
	Men 20-64	Single women 20-59	Married women 20-59
Central Clydeside	7.86	1.78	3.23
Strathclyde	7.14	1.66	3.06
North	6.43	1.56	2.50
North West	6.37	1.69	2.52
Remainder of Scotland	6.13	1.47	2.58
Wales	5.86	1.43	2.34
Yorks and Humberside	5.83	1.48	2.32
West Midlands	5.72	1.54	2.26
East Midlands	5.28	1.40	2.14
South East	4.88	1.29	1.97
South West	4.82	1.32	1.93
East Anglia	4.37	1.14	1.79
Scotland	6.92	1.62	2.89
England and Wales	5.43	1.41	2.17
Britain	5.57	1.43	2.23

Source: Townsend et al reference 87, derived from OPCS data.(17)

Table 3 gives the age standardised death rates for men and women of working age in various regions of Britain. The general South/North Gradient is evident(87) for men and married women, though not as distinct for single women.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

An analysis of deaths from smoking-related diseases by Health Authority, Local Authority, and Parliamentary Constituency areas showed great variation e.g. from 155 deaths/100,000 population in Oxford to 242/100,000 in the Northern Region[88]. Differences in morbidity between the regions also persist[40, 41].

The interaction between area of residence and occupational class is illustrated by Townsend in Table 4.[86] He points out that there are distinct regional differences in the size of the health gap between the richest and the poorest occupational classes. As the table shows it is in the North that the gap between the health of the rich and the poor is at its greatest[21].

Table 4

SMRs for all causes, 1979-80, 1982-83 by Region

(Men aged 20-64 and women aged 20-59)

	Men			Women		
Standard Region/ Country	I & II	IV & V	IV & V as % of I & II	I & II	IV & V	IV & V as % of I & II
North	81	152	188	80	136	170
Wales	79	144	182	79	125	158
Scotland	87	157	180	91	141	155
North West	83	146	176	86	135	157
Yorkshire & Humberside	79	134	170	78	120	154
West Midlands	75	127	169	77	113	147
South East	67	112	167	71	100	141
East Midlands	74	122	165	73	110	151
South West	69	108	156	70	96	137
East Anglia	65	93	143	69	81	117
Great Britain	74	129	174	76	116	153

Note: SMR for all men, and for all women, in Great Britain in 1979-80, 1982-83 is 100. Regions ranked by SMR for classes IV and V combined as a proportion of SMR for classes I and II combined. Women classifed on own, or husband's occupation.

Source: Townsend (1987) derived from O.P.C.S. data. See Ref. 86

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

What has given greater insight into the pattern of regional differences is the series of small area analyses which have flourished since 1980. Previous studies have looked at differences at the level of large areas such as regions or counties. However, several authors have detailed the potential for studies based on smaller areas,[89,90,91] and a number of recent technical advances explained in Section 7 have made such studies possible.

Details of some of the major studies are listed in Table 5. A number of general points can be made about the findings:

1. Large differences exist between communities within one administrative area. As the Greater Glasgow Health Board reports:

   > "In several communities (in G.G.H.B.) death rates are as low as or even lower than in the healthiest countries in the world -whereas in many others death rates are among the highest anywhere."[92]

   In Sheffield, Thunhurst found a difference in life expectancy for men of over 8 years between the most affluent and the most deprived wards.[93]

2. These large variations suggest that the concept of the North/South gradient in Britain is far too simplistic. In Townsend et al's studies in the Northern Region[87] and in Bristol,[94] for instance, it was found that the healthiest areas in the Northern Region compared well with the healthiest areas in and around Bristol. Such evidence is masked when analysis is carried out at the County or Regional Health Authority level. This issue should be considered in the light of point 3 below.

3. Several of these studies have shown very clearly the association between poor health and various indicators of social and material deprivation. This may be the key to the North/South gradient. Although there are very affluent areas in Scotland and the North, there is also the the greatest concentration of material deprivation and it is this factor which may determine the overall Regional health profile.

4. Some studies have been able to examine in more detail which particular factors in a deprived area are linked to the poor health record. Occupational class, unemployment rate and housing tenure differences "explained" some but not all of the observed differences in health.

In addition to the studies in Table 5, several areas have produced "local Black Reports" in which health profiles for specific areas have been drawn up and in some reports strategies have been put forward for local action on inequalities in health. These include reports for Merseyside,[95] Sheffield,[96] Glyndon, a ward in Greenwich,[97] Moyard estate in Belfast, Northern Ireland,[98] Glasgow,[99] Bloomsbury,[100] Coventry,[101] Manchester,[102] and Grimsby.(130)

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Table 5

Small area analyses in Britian in the field of deprivation and ill-health

Reference	Place and date of data collection	Indicators used	Findings
(103) Carstairs (1981)	37 municipal wards in Glasgow 23 in Edinburgh around 1971 census data.	looked at correlation between severity of deprivation (derived from Scottish Development Dept. indicators) and mortality and health service indicators.	Found good evidence of greater mortality and morbidity in areas of greater deprivation, except in perinatal and infant deaths. (Could not control for social class composition of wards.)
Greater Glasgow Health Board (1984)(92)	87 neighbourhoods in Greater Glasgow Health Board Area 1974-1983. 1981 census material, also 137 post-code sectors.	based on 6 separate indices of deprivation in each individual household. Mortality statistics, incidence of low-birth weight, and proportion of permanently sick	The 87 neighbourhoods were ranked according to SMR and divided into 5 equal quintiles. The average SMR for highest quintile was 2.3 times that of the lowest. There was a 4-fold difference between the highest and the lowest quintile in terms of the proportion of the population permanently sick. 137 post-code sectors were ranked according to their incidence of low birth-wieght and there was a 3-fold difference between the incidence in the lowest and highest quintile.
Crombie et al (1986)(104)	The 56 local government districts in Scotland 1979-83 centred on the 1981 census.	mortality rates for men and women aged 35-64 from coronary heart disease.	Confirmed the contrasting pattern of low coronary mortality rates in the East and high rates in the West of Scotland but with interesting inconsistencies. Within a cluster of very high mortality districts in the Clydeside connurbation were two districts with very low rates - to be investigated further.
(93) Thunhurst (1985)	Sheffield 1981-83 based on 1981 census material.	18 indicators used to define "Areas of Poverty" in Sheffield SMR calculated for each electoral ward for major causes of death and also life expectancy.	Tested for correlation between "Areas of Poverty" and health indicators. Found clear relationship between poverty (direct indicators) and all causes of mortality for both men and women. The relationship was stronger for early mortalities and for cancer mortalities in men. Also significant relationship between poverty and heart disease mortality in men. For men, found a difference in standardised life expectancy of over 8 years between the most affluent and the most deprived wards.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Reference	Place and date of data collection	Indicators used	Findings
Townsend, Simpson and Tibbs (1985)(94)	28 wards in Bristol 1977-80 - 81. 1971 census data	stillbirths and infant deaths, death rate for 15-64 year olds, death rate for over 65's and proportion of low birth weight babies. Several social and material deprivation indicators e.g.over-crowding, car owner-ship, unemployment rate, % children receiving school meals, disconnections of electricity supply	Tested for correlation between degree of deprivation and health status. The difference in health between the six least and the six most deprived wards was highly significant. Study concludes that "poor health is significantly correlated with deprivation."
Townsend, Corrigan & Kowarzib (1986)(105)	755 wards in London 1981 Census material Death rates 1979-82	Combines 4 indicators of depivation: % of unemployed, overcrowding factor, % households not owner-occupied, % household lacking a car.	Mortality rate in the most deprived wards nearly double that of the least deprived wards.
Townsend, Phillimore & Beattie (1986)(87)	678 local authority wards in the Northern Region 1981 census material, up to 1984 health material.	SMR's, low birthweight, rates of permanent sickness and dis-ability, combined to give an overall health index.. social indicators separate analysis by occupational class, and deprivation index combining measures of un-employment, car ownership, over-crowding.	Tested correlation between health, prosperity and deprivation. Found wide variation in SMR between top 10 and bottom 10 wards. Northern Region emerged badly on rates of permanent sick-ness and disability - 64% of wards had levels of permanent sickness worse than the England and Wales average, with a very uneven distri-bution across the region. The Region had much better record on birthweight. Correspondence between ill-health and deprivation extremely close. At district level areas with poor health were those with marked deprivation and vice-versa. The different occupational class composition of wards was found to explain some of the high mortality in areas, but not all. The strongest association between health and deprivation variables was with car ownership - lack of a car being a proxy for low income.
Fox et al (1984)(45)	from L.S. study 1971-81. 36 geographic clusters in England & Wales each having distinctive socio-economic identity (after Webber and Craig)(43)	Mortality by area of residence, housing tenure, occupational class and economic position.	looked at mortality of individuals in LS study - linking them directly to the data (not possible in the above studies). Found a pattern of low mortality in "high status" clusters and high mortality in "low status clusters". Went on to see if variation could be "explained" by housing tenure, occupational class or economic position. Found only a part of the cluster difference could be "explained" by these factors.

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Further small area studies have covered unemployment and hospital admissions in children,(199) and the mapping of childhood accidents in Haringay.(255)

Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

2.6 Health and Ethnic Origin

It is useful to define precisely what is meant by the terms in this section. Adopting Donovan's definition (1984)[106]

> ""minority", "ethnic", or "ethnic minority" group is used to describe any group of people who share a cultural heritage, are not part of the majority, and may experience varying degrees of discrimination - the term "black people" in general tends to refer to people of Asian or Afro-Caribbean descent who share the common experience of differentiation or racial discrimination in Britain because of the colour of their skin."[106]

It is also important to point out, as do Townsend and his colleagues,[87] that it can be misleading to lump all members of ethnic minorities into one disadvantaged category. There is great variation in health status among the ethnic minorities and it is more fruitful to examine in which areas specific disadvantages lie.

> "It is we believe mistaken to treat being black, or old and alone, or single parenthood as part of the definition of deprivation. Even if many among these minorities are deprived, some are not and the point is to find out how many are deprived rather than operate as if all were in that condition. It is the form their deprivation takes and not their status which has to be measured."
>
> Townsend et al 1986[87]

There are a number of specific illnesses which are nowadays far more common in certain ethnic minorities than in the population as a whole, for example, rickets in children of Asian origin, sickle-cell anaemia in people of Afro-Caribbean descent, and tuberculosis in several immigrant groups. The evidence on these is reviewed by Donovan (1984),[106] and a particular focus on health in childhood is given by the National Childrens Bureau (1987).[36] McNaught (1985)[107] reviews the evidence on health and healthcare for ethnic minorities and discusses race relations policy in the NHS.

The only major study of immigrant mortality in England and Wales was carried out by Marmot et al and published in 1984.[108,109] It focussed on people born outside those two countries who were over 20 years of age. It therefore excluded British born members of minority groups and included British subjects born abroad. The mortality rates for most immigrant groups were lower than that of their countries of birth, indicating that healthier than average individuals were "selected" for immigration. The exception was for immigrants from Ireland whose mortality was higher than that in Ireland or in England and Wales. Table 6 summarises the main findings.

Balarajan et al (1984)[110] carried out a detailed analysis of deaths in England and Wales from 1975-77 of people born in India, Pakistan or Bangladesh. This confirmed the findings of Marmot et al[108] and provided further insight into mortality differences.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Observed mortality for these groups was higher than expected for infective and parasitic disease, diabetes, ischaemic heart disease, cerebrovascular disease, and cirrhosis of the liver. Fewer than expected deaths were due to cancer (notably lung cancer) and chronic bronchitis. Comparing different groups from the sub-continent with each other, proportional mortality ratios for cancer were lower for Hindu groups than for Moslems and lowest for Punjabis. Ischaemic heart disease rate was highest in Moslems. Significantly more Punjabi men died from cerebrovascular disease and cirrhosis of the liver. Diabetes was commonest among Gujaratis.

Table 6

Summary of main findings on immigrant mortality study in England and Wales 1970-78, Marmot et al (1984)(108,109)

Mortality by cause	Comparison with death rates for England and Wales
Tuberculosis	high in immigrants from Indian sub-continent, Ireland, Caribbean, Africa and Scotland.
Liver cancer	high in immigrants from Indian sub-continent, Caribbean and Africa.
Cancer of stomach, large intestine, breast	Low mortality among Indians.
Ischaemic heart disease	high mortality found in immigrants from Indian sub-continent.
Hypertension and stroke	strikingly high mortality among immigrants from the Caribbean and Africa - 4 to 6 times higher for hypertension and twice as high for strokes as the level in England and Wales.
Diabetes	high among immigrants born in the Caribbean and Indian sub-continent.
Obstructive lung disease (including chronic bronchitis)	low in all immigrants in comparison to ratio for England and Wales.
Maternal mortality	high in immigrants from Africa, Caribbean, and to a lesser extent the Indian sub-continent.
Violence and accidents	high in all immigrant groups.

Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Analysis of the 1978 and 1980 General Household Survey showed that smoking and drinking habits varied considerably by country of origin.(111) Heavy drinking was significantly higher in Irish men with the lowest levels in those born in the Indian sub-continent. Heavy smoking was significantly higher in both Irish and Scottish men with the lowest levels again recorded in those born in the Indian sub-continent. Similar smoking patterns were found for women.

Attention has been focussed in the early 1980's on the health of babies born to mothers coming from the new Commonwealth and Pakistan countries.

Figure 8 gives the OPCS statistics on outcome of pregnancy for 1984,(15) showing stillbirth, perinatal, neonatal and postneonatal mortality by country of birth of mother. Infant mortality rates are strikingly high for babies of mothers born in Pakistan and to a certain extent in babies of mothers from the Caribbean.

A number of studies centred around maternity hospitals have tried to unravel the causes of these high rates. Terry et al (1980)(112) studied all births occurring in one hospital in Birmingham in 1979. Most mothers fell into the social class IV and V categories. A high proportion of the mothers of Indian origin would be classified in a low-risk group based on age and parity but had the highest stillbirth and perinatal mortality rates. Congenital malformation rates were highest in the Pakistani and Bangladeshi groups. The study concluded that the difference in perinatal mortality rate was apparently not related to maternal age, parity or social class. Lumb (1981)(113) studying babies born to mothers of Asian origin in Bradford over the five years from 1974-78, found that the perinatal mortality rate was persistently higher than for babies of mothers born in the U.K. Factors operating in favour of Asian born women were: fewer teenage pregnancies, lower rates of illegitimacy and fewer smokers. Increased risks for the Asian group included: more women over 35, lower social class, higher parity, shorter pregnancy intervals, previous perinatal deaths, shorter duration of antenatal care, anaemia and shorter gestations.

Gillies et al (1984)(114) followed up this study in Bradford in 1975 - 81, looking at all births and infant deaths occurring in one health distirct. They found large differences in mortality between babies of Asian-born mothers and those of U.K.-born mothers, associated with congenital abnormality, largely independent of social class. Risk factors found, which the authors suggest might explain the findings, included low maternal height, poor antenatal attendance, anaemia, high parity of Asian-born mothers, late child-bearing, high number of low birthweight babies and consanguinity (marriages between first cousins were apparently common in Pakistani marriages in Bradford in 1981.(114))

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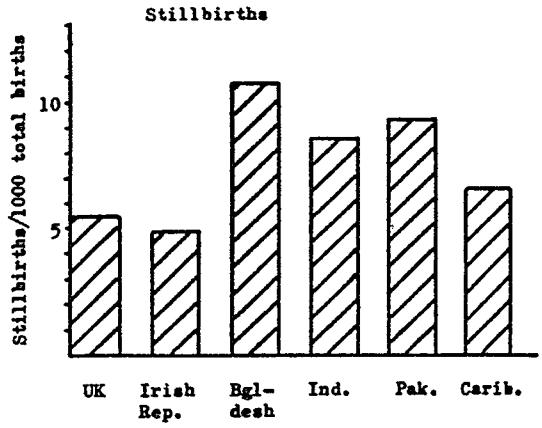
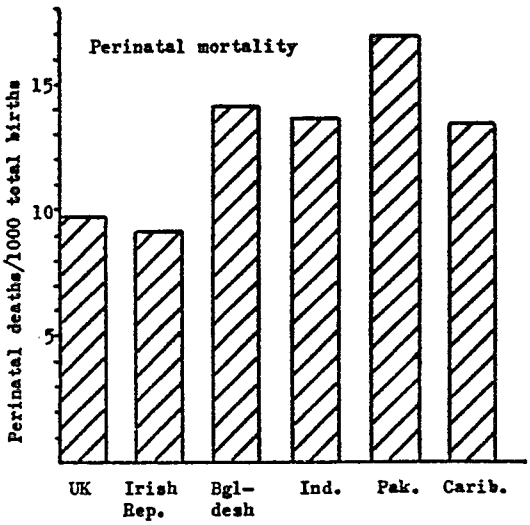
Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

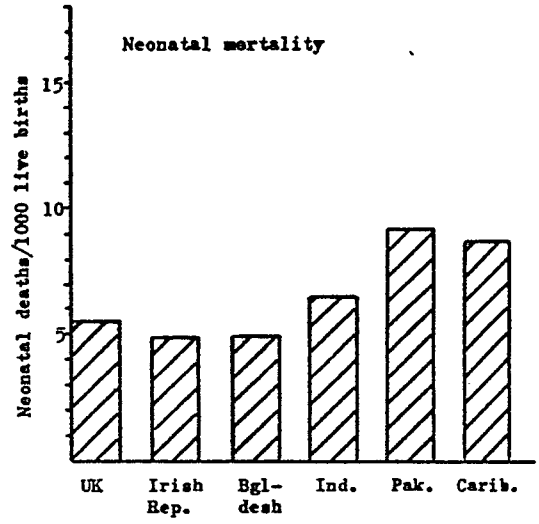
Figure 8

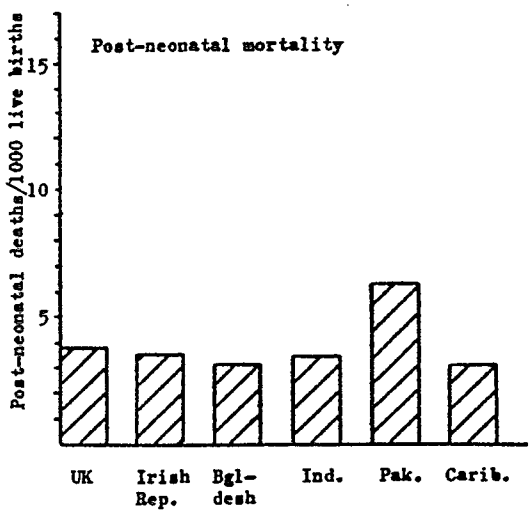
Outcome of pregnancy by mother's country of birth, England and Wales, 1984

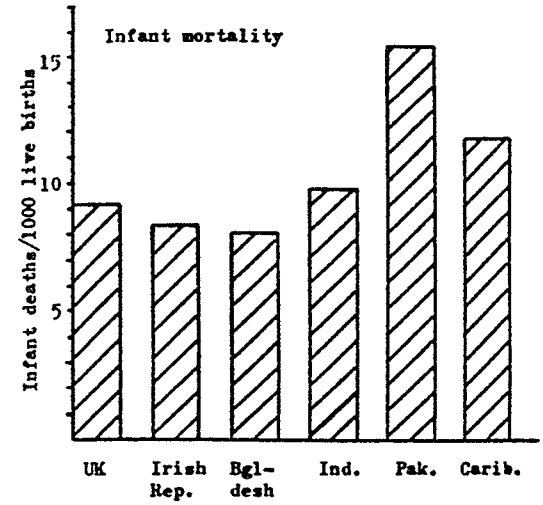
UK	United Kingdom
Irish Rep.	Irish Republic
Bgl-desh	Bangladesh
Ind.	India
Pak.	Pakistan
Carib.	Caribbean Commonwealth











Source: O.P.C.S. drawn from data see ref. 15

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

How far pregnancy outcome was affected by material deprivation is not assessed in the above studies. Fitzpatrick and Scambler[115] highlight data from the 1981 Labour Force Survey showing that minorities from the New Commonwealth and Pakistan were over-represented in the manual and working classes, especially those of West Indian and Guyanese origin. They also experienced very high unemployment, again notably those of West Indian and Guyanese origin. How the cultural and material factors interact to affect the life-chances of ethnic minorities is largely unexplained.

Studies are hampered by the way health information on ethnic groups is collected. Researchers have to rely almost entirely on the country of birth recorded on documents such as birth and death certificates to infer ethnic origin. Thus apart from infant mortality data, there is still very little information on the health of British-born children of ethnic minority groups.

See section 8 for details of health and social service initiatives on health and race.

2.7 Conclusions

Data on health inequalities in the early 1980's confirm much of what the Black Working Party found on health inequalities in the early 1970's, with the addition of extended analyses on several issues. For example, data on occupational class mortality has now been extended to ages over 65 and still a substantial class gradient persists. The OPCS Longitudinal Study has provided data free of numerator/denominator bias, and has confirmed a clear gradient under such conditions.

The experience of illness by occupational class has been extended into areas of self-perceived health and well-being. Lower occupational groups have been found to experience more illness which is both chronic and incapacitating. Although it is taken for granted that sickness will happen to almost everyone sooner or later, it seems that lower occupational groups experience it earlier and this must be seen as a major inequality in a welfare society.

Other indirect measures of affluence and poverty, like housing tenure and employment status also highlight inequalities in health. Owner-occupiers continue to have lower rates of illness and death than private tenants, who in turn have lower rates than local authority housing tenants. It is well known, and confirmed in recent studies, that the unemployed have much poorer health than those with jobs. It is now also beyond question that unemployment causes a deterioration in mental health and there is increasing evidence that the same is true of physical health.

Women can expect to live longer than men and have lower mortality rates at every stage of life. However, women record higher levels of morbidity than men, particularly from middle-age onwards. Research is only just beginning to unravel the complexities of inequality in health for women. Health experience has been found to differ for women and men in relation to marital status, employment, and presence of children in the home, as well as occupational class.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

The overall North/South regional differences in health in Britain are still evident, but what is now becoming apparent is the great inequality in health which can exist between small areas in the same region. Areas suffering social and material deprivation have been found to have much poorer health profiles than neighbouring affluent areas. Furthermore, the gap between the health of the rich and the poor is greatest in the North.

Information on the health of ethnic minorities is mainly limited to studies of adult immigrants born outside England and Wales, with hardly any information on the health of the second generation. A varied picture emerges. Mortality rates from lung cancer and chronic bronchitis for example are lower in most ethnic groups than in the U.K.-born population. On the other hand deaths from accidents are disturbingly higher in all immigrant groups. There is strikingly high mortality from hypertension and strokes among people of Caribbean and African origin and markedly higher mortality rates for babies of mothers born in Pakistan and to a certain extent for babies of mothers from the Caribbean.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

SECTION 3

RECENT TRENDS

There is no doubt that the health of the population as a whole has continued to improve over recent years, measured for example, by life expectancy. In 1981 a new-born boy could expect to live to 69.8 years and a girl to 76.2 - an improvement over the previous decade of over 1 year.(76) Other measures of the population's health, like height and dental health, show steady improvement since 1971-72.(78) As death rates from infectious diseases continue to decline, deaths in childhood have become less common, and a greater proportion of the population can now expect to live to middle and old age. This can be seen as increasing equality among individuals in the population.(116)

Nevertheless inequalities in health between different social groups within the population still exist on a substantial scale - as the evidence in Section 2 confirms. An important question now is whether these inequalities in health are increasing, decreasing or staying the same. The Black Report, reviewing evidence from 1931-1971, concluded that the gap in health between different social groups had either stayed the same, or in some cases had widened. New evidence has been presented since then on trends over the past decade, and re-assessments of the 1931-71 evidence have also been carried out; these will be discussed in this section.

3.1 Have inequalities in health widened?

There are a number of fundamental problems in measuring health trends over time, but several recent studies have found ways of overcoming them satisfactorily. The results of these studies, taken together, give convincing evidence of a widening of health inequalities between social groups in recent decades, especially in adults. In general death rates have declined more rapidly in the higher than in the lower occupational classes, contributing to the widening gap. Indeed in some respects the health of the lower occupational classes has actually deteriorated against a background of general improvement in the population. There was also a widening gap between manual and non-manual groups in their rates of chronic sickness from 1974 to 1984, and during the late 1970's the gap widened for acute sickness too.

The exception to the widening trend was in relation to deaths in babies under one year. While there has been little change in the differential for deaths around birth and in the first month of life, great improvements have occurred in the postneonatal period (age range one month to one year). There was a dramatic decline in postneonatal death rates during the 1970's in all classes, but especially for class V, and thus the gap in mortality narrowed considerably. Although there has been very little further improvement from 1980 to 1984, for manual or non-manual classes, the evidence does illustrate that the class differential is not inevitable and can be reduced.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

The main evidence on trends is outlined below, after a discussion of the measurement problems.

3.2 Measurement Problems

The seemingly simple task of following trends in health over time is fraught with difficulties, particularly in relation to occupational class comparisons. These problems have been reviewed recently by Wilkinson (1986)[117], Illsley (1986)[118] and Le Grand and Illsley (1986)[116]. Wilkinson (1986)[117, 119], has also detailed ways of overcoming many of the problems. From these reviews five main obstacles have been identified, which need to be borne in mind when assessing research on occupational class time trends:

1. Numerator/Denominator bias: In the calculation of death rates the occupation of the deceased is taken from death certificates, while the total number of people in each class is calculated from occupations recorded in the 10-yearly national census. Misrecording of occupation in either source introduces bias into the calculation. OPCS points to a considerable increase in numerator/denominator bias in the latest Occupational Mortality Decennial Supplement based on the 1981 census.[17] This census used the Registrar General's 1980 classification of occupations which changed the social class of some occupations. The recording of occupations on death certificates, however, is still much less precise and has not led to the same shift in occupations between classes. The social class mortality rates, in the form presented in the Decennial Supplement, may be misleading, especially for class V, unless analysed with care. Many believe that the data can be used by comparing manual with non-manual catagories, or combining data on classes I and II and comparing it with data on class IV and V combined.[21, 20, 120, 121]

2. Re-classification

   Repeated re-classification of occupations at each census since 1931 has made it difficult to compare occupational classes over such a time span, unless adjustments are made to allow for the re-classification.

3. Changing size of classes

   The proportion of the population in each social class has changed over time. In particular, there is a smaller proportion of the population in class V and a larger proportion in classes I and II, due to an upward shift in occupations. It should be noted that class V is also being eroded by unemployment as well as by upward mobility into higher classes.[122] Comparisons of class I with class V over 30 to 50 years are therefore not comparing similar-sized segments of the population. However, comparison of combined classes I and II with combined classes IV and V would compare large and roughly equal-sized slices of the population.[21]

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

4. Changing status?

Linked to the change in size of each class may be a change in the relative status of each class. For example, the status and life-style of the much smaller class I in 1921 or 1931 may have been very different to the status of the expanded class I in 1981, so again the studies may not be comparing like with like.

5. Based on small proportion of total deaths

Some comparisons have been based on the mortality of men aged 15 - 64. In 1921 deaths to this group accounted for 40% of all male deaths, but by 1971 they only accounted for 25%. Therefore only limited conclusions can be drawn from such data, though it is still true to say that they give a representation of premature adult male mortality.

3.3. Evidence on Trends

Marmot and McDowall (1986)[20] chose to analyse death rates in men and married women in terms of manual and non-manual class to overcome numerator/denominator difficulties and thus be able to make use of the Decennial Supplement for 1979/83.[17] They argued that even if some occupations had been re-classified into different social classes in the 1981 census data, there was no evidence that there would be any serious mis-classification between these two very distinct groups. They also restricted their analysis to the recent past to avoid long-term complications.

Figure 9 summaraises the results. Marmot and McDowall concluded from the analysis that there had been a fall in overall mortality for both manual and non-manual classes but the rate of decline had been greater in non-manual groups. Consequently, the social gap had widened. These widening inequalities were apparent in mortality from all four classes. Coronary heart disease mortality had declined in non-manual classes, but only in Wales had there been a noticeable decline in manual classes. For married women, lung cancer and coronary heart disease mortality had fallen in non-manual classes but had increased in manual classes.

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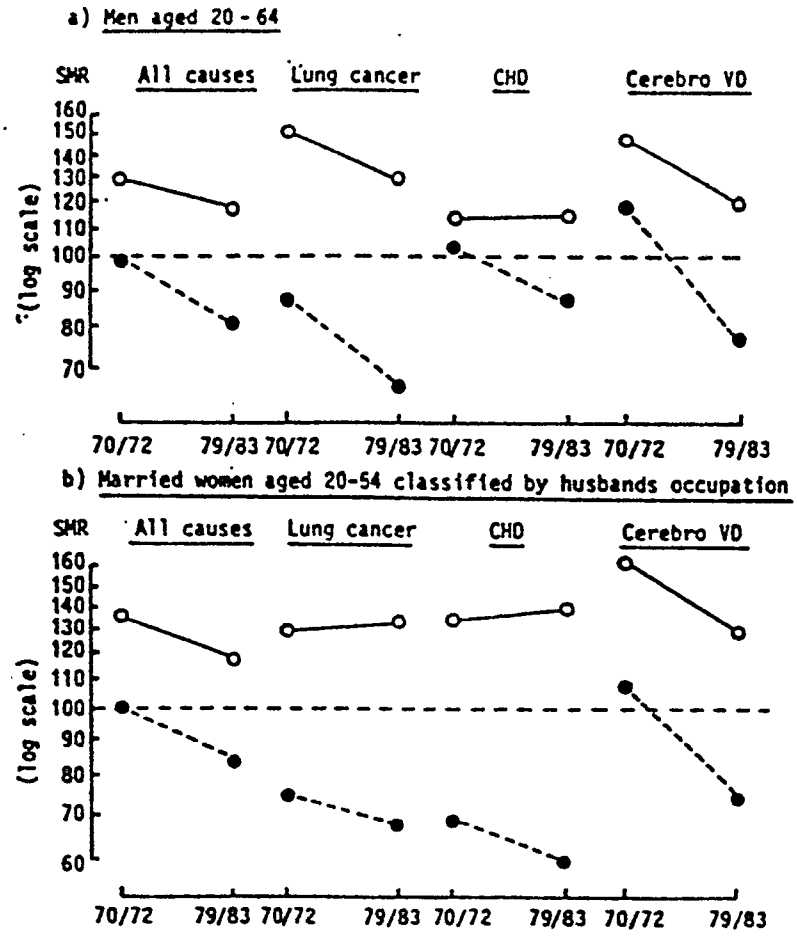
Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Figure 9

Standardised mortality ratios* for select causes of death in Great Britain 1970-72 and 1979-83 for manual(○—○) and non-manual (●—●) groups.



*For each cause the SMR in 1979-83 is 100 for each sex.

Source: Marmot + McDowall (1986) see ref. 20

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Townsend(21) analysed the Decennial Supplement data for 1949-53 to 1979-83, by combining class I with class II and class IV with V. He found that over the past 30 years death rates for each age range declined more rapidly in the two top occupational classes compared to the two bottom occupational classes. For example in men aged 45-54 death rates declined by 37% in the top two classes but by only 7% in the bottom two classes over the 30 years. The equivalent figures for women were 35% and 7%. In addition a larger number of causes of death showed a class gradient, with higher mortality in the lower occupational classes.

Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

The OPCS Longitudinal Study is specifically designed to be free of numerater/denominator bias as the sample's death certificates and other records have been linked to the census records. It can also correct for re-classification, and as it only covers deaths from 1971 onwards it does not face some of the problems of longer-term comparisons. Preliminary results from the study comparing the years following the 1971 census with 1981-83, show a widening gap in all cause death rates between manual and non-manual classes.(123) When specific causes of death were examined, the Longitudinal Study found that differentials had widened since 1971 for lung cancer and circulatory diseases, particularly ischaemic heart disease, while for other causes of death the gap appeared to have remained the same or narrowed.

Table 7 illustrates recent trends in deaths in babies and infants in the first year of life, comparing combined classes I and II with combined classes IV and V.(124) Over the 10 years, although there was a general decline in death rates, the occupational class differences persisted for stillbirths and deaths in the first week (perinatal) and first month of life (neonatal). For example the perinatal death rate of classes IV and V fluctuated at around 150% of the rate for classes I and II during the whole period. Macfarlane and Mugford(42) found a similar differential in 1970-72, so the situation has remained static for nearly 15 years.

However, the picture for postneonatal deaths, (age one month to one year), is somewhat different. There was a clear narrowing of the mortality gap between classes I and II and IV and V in the early 1970's, though there has been little, if any, improvement since then. Pharoah and Morris(125) have traced trends in post-neonatal mortality since the second world war. From 1949-50 to 1970-72 there was a rapid decline in death rates for classes I, II, III and IV, but as they reduced at the same pace the relative differential between these four classes remained the same. The decline in class V rates was much smaller, and therefore the differential between it and the other classes widened during that time. After 1970-72 there was another sharp overall decline in death rate but this time the greatest improvement was for class V, so the gap in mortality between the classes narrowed.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Table 7

: INFANT MORTALITY BY OCCUPATIONAL CLASS 1975 - 84

DEATHS	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
STILLBIRTHS/1000 total births										
Rate for classes I & II	7.9	7.7	6.8	6.6	6.0	5.7	5.3	4.8	4.6	4.2
Rate for classes IV & V	12.6	11.3	11.0	9.8	9.4	8.4	7.6	7.6	6.9	7.2
Rate for classes IV & V as percentage of rate for classes I & II	159%	146%	161%	148%	156%	146%	143%	156%	151%	168%
PERINATAL DEATHS/1000 total births										
Rate for classes I & II	15.0	13.8	12.6	12.1	11.4	10.7	9.3	8.7	8.1	7.7
Rate for classes IV & V	22.7	20.5	19.5	17.5	17.1	15.5	13.8	13.5	12.5	12.3
Rate for classes IV & V as percentage of rate for classes I & II	151%	148%	154%	144%	150%	144%	148%	153%	154%	159%
NEONATAL DEATHS/1000 live births										
Rate for classes I & II	8.3	7.4	7.0	6.9	6.7	6.2	5.0	4.9	4.3	4.3
Rate for classes IV & V	12.3	11.0	10.4	9.4	9.5	8.9	8.0	7.4	6.9	6.5
Rate for classes IV & V as percentage of rate for classes I & II	148%	148%	148%	136%	140%	144%	160%	150%	157%	148%
POSTNEONATAL DEATHS/1000 live births										
Rate for classes I & II	3.1	2.7	2.9	3.0	2.9	3.1	2.8	3.1	2.8	2.5
Rate for classes IV & V	6.4	5.8	5.7	4.9	6.0	5.2	5.4	5.1	5.3	4.5
Rate for classes IV & V as percentage of rate for classes I & II	202%	214%	196%	160%	204%	167%	192%	164%	186%	178%
INFANT DEATHS/1000 live births										
Rate for classes I & II	11.5	10.2	10.0	10.0	9.7	9.3	7.8	8.0	7.2	6.9
Rate for classes IV & V	18.7	16.8	16.2	14.4	15.5	14.2	13.5	12.5	12.2	11.0
Rate for classes IV & V as percentage of rate for classes I & II	162%	164%	162%	144%	159%	152%	173%	155%	168%	159%

Source: derived from O.P.C.S. data Series DH3, various years.

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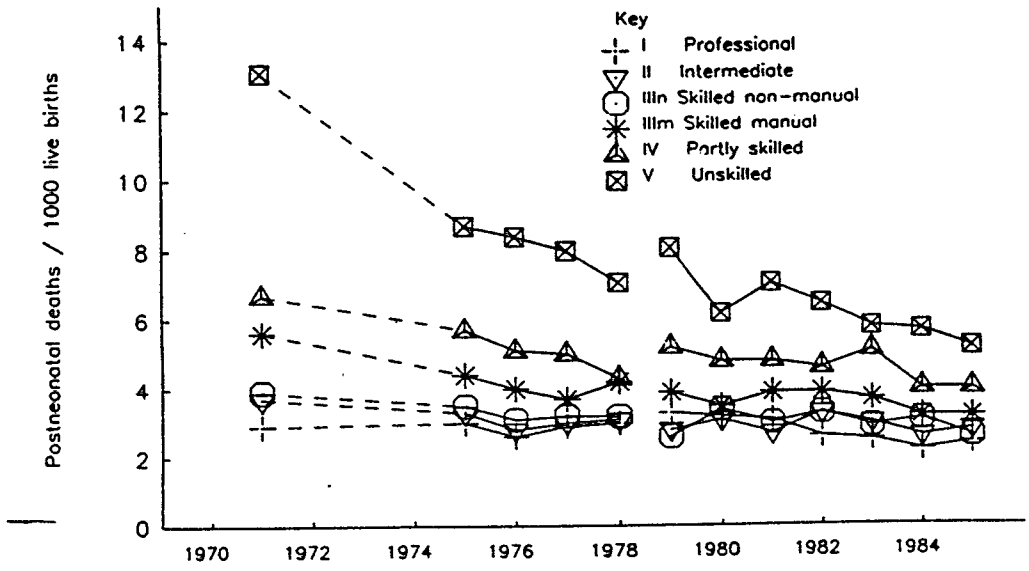
Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Macfarlane[126] points out that since 1975 postneonatal death rates have improved very little for non-mannual classes, and since 1979 there has been little improvement for manual classes either. The mortality gap has thus remained fairly constant for the past 5 years. See Figure 10. The still unanswered question is why the ealier improvement in class V rates occurred. The reasons seem to be complex and are still being investigated, but certainly one of several relevant factors appears to be the reduction in average family size, particularly in class V.[125,126]

Figure 10

Postneonatal mortality by father's social class, England and Wales



Source: Macfarlane, A (1987) from OPCS Mortality Statistics.

Trends in chronic and acute sickness recorded in the General Household Survey have been analysed for the decade from 1974 to 1984.[28] Figure 11a shows the trends in chronic sickness for manual and non-manual men and women. Manual groups had higher rates of chronic sickness than non-manual groups throughout the decade and the gap between the two groups widened over the 10 year period. For men the widening occurred particularly from 1974 to 1979, and since then the gap has remained fairly stable. For women the gap between manual and non-manual groups widened throughout the 1970's and continued to widen in the 1980's.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Figure 11a and Figure 11b

Fig. 11a Percentage of males and females reporting long-standing illness and limiting long-standing illness by whether non-manual or manual socio-economic group: 1974, 1979 and 1984, Great Britain

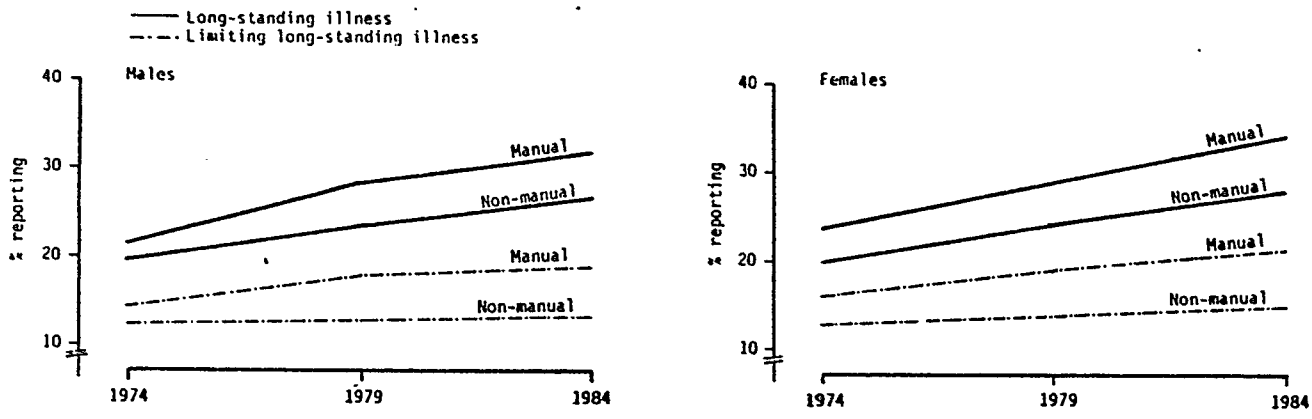
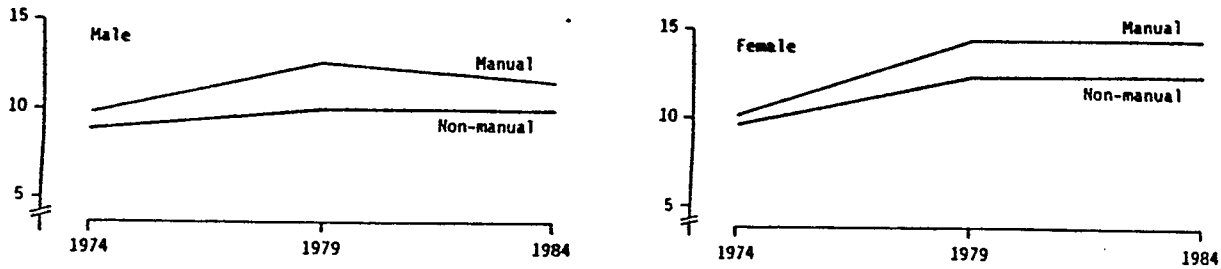


Fig. 11b Percentage of persons reporting restricted activity in the 14 days before the interview by sex and whether non-manual or manual socio-economic group: 1974, 1979 and 1984, Great Britain



Source: General Household Survey for 1984 see ref. 28

Trends in acute sickness are also shown in Figure 11b. In both men and women rates of acute sickness were consistently higher for manual than for non-manual groups. There was a slight widening of the gap between the two groups between 1974 and 1979, then it remained stable from 1979 to 1984.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

So much for the trends over the last decade. The objections to comparisons over much longer time spans are far more serious and need more sophisticated techniques to try to overcome them. Three studies recently have re-assessed the data on mortality trends from 1921-71, making adjustments for expansion and contraction of numbers in different classes; for changes in classification of occupations over 50 years; and covering the bulk of the population rather than relatively small sections (thus taking into account problems 3 and 5 listed at the beginning of this section).

Preston et al (1981)[127] applied 3 measures of inequality to the experience of men, women and children in England and Wales from 1921-72. The measures were: the Gini coefficient, the Index of Dissimilarity and the Slope Index of Inequality. All three indices indicated increasing inequalities from 1930-32 onwards with the greatest inequality in health achieved in 1970-72. As Preston et al point out:

> "All classes have profited from mortality decline, but higher-status groups have profited more than most."[127]

Pamuk (1985)[128] confirmed these findings by using the Slope Index of Inequality, based on the mortality level of all five social classes and their proportionate share of the population. She took 143 occupations which could be traced consistently between 1921 and 1971, to overcome re-classification difficulties (problem 2). From this analysis she concluded that class inequality in mortality among men declined in the 1920's but increased again during the 1950's and 1960's so that by the early 1970's, it was greater than it had been in the earlier part of the century. For married women, there was a similar increase in inequality between 1949-53 and 1970-72. The class differentials in infant mortality declined dramatically in absolute terms, but still increased in relative terms, as did the adult trends.

Koskinen (1985)[129] analysed causes of death by occupational classes from 1921-72 in England and Wales using a modified Index of Dissimilarity as an indicator of the relative differentials between the classes. This index is the number or proportion of deaths which would need to be reallocated between classes in order to give equal death rates in all classes. He also examined the possible role of medical care in influencing the class differentials by comparing trends in mortality from causes thought to be amenable to medical intervention with other diseases. The analysis of "all causes" of death suggested that the differences between occupational classes had become much wider than they used to be and change in the class composition of the population was not responsible for the increase in inequality. The class differentials were much larger at the beginning of the 1970's than ever before. The widening differentials could not be explained by a few specific diseases as in 31 out of the 32 causes of death analysed, the higher classes did better than the lower classes.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Turning to "diseases of poverty" (i.e. diseases with a consistent inverse class mortality gradient) regarded as amenable to medical intervention, (such as T.B. and cancer of the cervix), Koskinen[129] found no evidence of diminishing class differentials in any of them. Among married women the growth of inequalities had been fastest in those diseases where medical treatment is thought to be effective. For "diseases of poverty" not amenable to treatment there was a marked steepening of the class gradient, especially since the early 1950's. He concluded that the health care system had not succeeded in diminishing class inequalities.

If the methods used in these three studies can be shown to be appropriate for the analysis, they will have helped settle the debate on whether class differentials have widened in the second half of this century.

3.4 Trends in the sex differential

In contrast to considerations of occupational clas, trends in sex differentials in mortality do not have the same measurement problems. Life expectancy at birth has been increasing in both men and women throughout this century, but during that time women's life-expectancy has always been greater than men's.[77]

In recent decades the gap in life-expectancy has been increasing. For example, in 1950 women could expect to live 5 years longer than men, by 1981 they could expect to live 6.4 years longer.[76]

There is evidence, however, that the difference between the mortality rates for some major causes of death may be declining. For instance, Lopez (1984)[131] has traced the sex ratio trends for lung cancer from 1950-79. The sex ratio for lung cancer mortality showed a peak around 1960, when male death rates were 9 times greater than female death rates in England and Wales. Since then, the ratio has been steadily declining, mainly because the female death rate from lung cancer was rising faster than that for men. By the late 1970's, the male death rate had fallen from 9 times to 4 times the female rate. For other causes of death showing a large excess of male deaths, like accidents, the ratio of male to female death rates has been falling.[132] Unfortunately, some of this reduction in inequality seems to have been brought about by rising female death rates for these particular causes of death.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

SECTION 4

HEALTH SERVICES: EQUAL ACCESS FOR EQUAL NEED?

There has been much debate about whether the national health services are equally accessible to all social groups. Some of the studies reviewed by the Black Working Party suggested that access to those who needed care was in some cases biased in favour of the non-manual socio-economic groups. Equality in this context can have a variety of meanings. On page six aspects of equality were mentioned: equal access to available care, equal treatment for equal cases and equal quality of care.(3) A fourth aspect is equal access to the service for equal need.(133) The fourth aim may lead to an element of positive discrimination in services in favour of those with the greatest need. Measuring true "need", however, is an exceedingly difficult, if not impossible, task.(14) That is perhaps why the argument goes on about whether or not equal access for equal need has been achieved.

4.1 Has equality been achieved?

It is difficult to get a comprehensive overview of how the position has changed in the health services over the past decade. Although some recent studies could find no evidence of bias in favour of any social group in relation to G.P. consultation rates, there is no room for complacency. Other studies have highlighted examples of poorer provision of services in more deprived areas; physical access difficulties for a small proportion of the population-notably among the elderly and manual groups; differences in the quality of care which appeared to favour higher occupational classes; and much lower uptake of preventive services by lower social groups. What is not known is the extent of such inequalities. On the other hand there are certainly examples of health and social service workers making strenuous efforts to reduce the inequalities they have identified, and these important initiatives are outlined in Section 8.

4.2 Physical access

Studies which have looked at availability of services in different areas, and physical access problems give a mixed picture of progress. For example, Knox (1979)(134) looked at the location and accessibility of G.P. surgeries in Aberdeen. He found that the location of the surgeries clearly favoured the longer-established middle-class districts of the city, and the deprived areas were poorly served. When car-ownership was considered as an additional factor, it was found that the high levels of car ownership in the owner-occupied outlying areas of the city extended accessibility to services quite markedly, while there continued to be very low levels of accessibility in the outlying local authority estates. Whitehouse (1985)(135) confirmed that transport difficulties to G.P. surgeries appeared to have a deterrent affect on the use of the service.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Carmichael (1985)[136] found that the availability of dental services in Newcastle-Upon-Tyne was greater in more affluent areas, and poorer in officially designated "priority areas". In contrast Lunt (1985)[137] reports improvements in the distribution of hospice care for terminally ill patients. A 1980 survey had shown considerable regional inequalities in provision, with the South-East generally much better off than the rest of the country. Since then the imbalance has been reduced by differential funding for hospices.

An O.P.C.S. national survey in 1977 investigated access to primary health care in terms of ease of journey, use of appointment systems, doctors' approachability, ease of getting home visits and so on.[138] Most people found the services easily accessible. The proportion of people reporting difficulties was relatively small, between 5% and 10% of all informants, though the report did point out that this would represent over 2 million people nationally. As expected those in rural areas were more likely to experience difficulties than urban dwellers, but age, sex and social class proved to be more important factors. Problems were most common amongst the elderly, especially manual group women. People in social classes IV and V were less likely than others to use ophthalmic, dental and chiropody services, in line with previous studies on preventive services.

4.3 Quality of care

The quality of services is also important. Further studies on G.P. consultations have shown differences in G.P. responses to different social groups. For example, one study found that higher social class patients received more explanations voluntarily than did lower class patients.[139]

A study of home-visiting in a large inner London general practice found that there was a steady increase in the proportion of home-visits from class II to class V, but the proportion of home-visits was higest of all in occupational class I. When distance was also taken into consideration, class I patient living close to the health centre had by far the highest proportion of home-visits, more than double that of any other occupational class. Of the patients living farthest away from the health centre occupational class I again had the highest proportion of visits and class V the lowest.[140]

There is also evidence that classes I and II patients are more likely to be referred to specialist services by their G.P. than classes IV and V patients, particularly in the case of older women.[141]

4.4 Use of primary care services

There is plenty of evidence that members of lower occupational classes make less use of preventive services for themselves and their children. Analysis of the second national morbidity survey of general practice (1982)[142] confirmed the occupational class gradient in uptake of preventive services.[141, 143] Differential use of services has also been recorded for: screening and preventive services in Wales;[295] attendance at local authority

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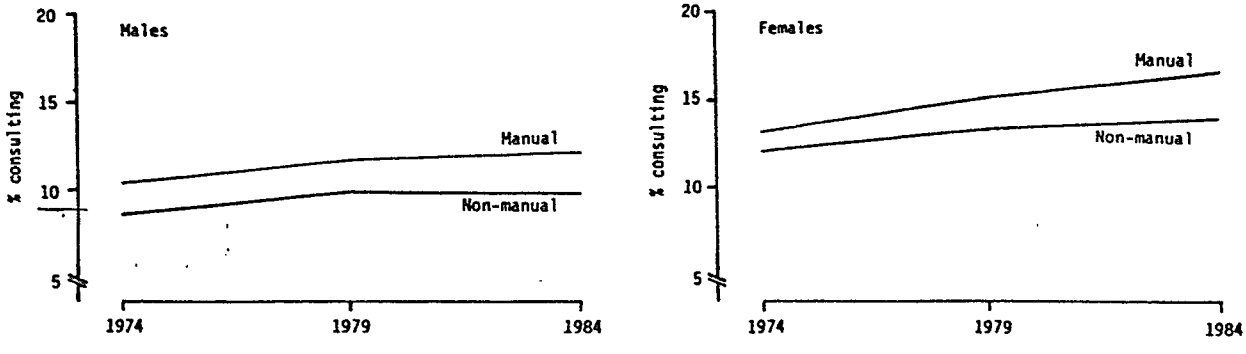
Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

developmental assessment clinics for pre-school children[144], frequency of attendance for dental services,[145, 41, 138], attendance at well-woman, well-man and cervical cytology clinics[146] and use of orthodontic services.[147]. This raises the question of why these services are used less by the lower socio-economic groups. Is it because of difficulties encountered using the services or different perceptions of the need for preventive care? Possible explanations are discussed further in Section 6.

When the full range of primary care services (preventive and curative) are considered, the problem of assessing "need" arises. Figure 11 on page 43 indicated the potential demand for health care and suggested that manual groups would have greater need for health services than non-manual groups. Figure 12 shows use of G.P. services by the two groups and indicates that manual groups do indeed use G.P. services more than non-manual groups.[28]

Figure 12

e. Percentage of males and females consulting a NHS GP in the 14 days before interview by whether non-manual or manual socio-economic group: 1974, 1979 and 1984, Great Britain



Source: General Household Survey for 1984 see ref. 28

But does their use of services completely match their increased need? This is a key question and one which has proved difficult to answer particularly when sex and age differences in use are also taken into consideration.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

In 1980 Collins and Klein[148] analysed newly available data from the 1974 General Household Survey. In 1974, (but not in other years) people who reported both illness and a G.P. consultation were asked whether their consultations had been about the reported illness, thus allowing a more direct comparison of the link between use and need. They found that among men who reported no illness the professional group had higher consultation rates than the rest of the population. Amongst men who reported acute sickness or chronic sickness without limitation manual groups had higher consultation rates than non-manual groups. For men with chronic limiting illness and for women in all catagories consultation rates were not systematically related to socio-economic group. From these results it was concluded that "The NHS had achieved equity in terms of access to primary health care."[148] This study has been widely critisized for drawing such sweeping conclusions from the limited data and from the restricted aspect of the system studied.[149, 150]

The General Household Survey has recently re-analysed the 1974 data too, with some refinements on the technique used by Collins and Klein and with the inclusion of data on children.[28] The study found that for given rates of sickness those in the manual socio-economic groups were more likely to consult a G.P. than those in the non-manual groups. The result was clearer in the case of acute than for chronic sickness and more marked for men than for women. The conclusion was that from 1974 data "for the aspect studied there was no evidence of bias".[28] As similar information was collected in the 1986 G.H.S., an updated analysis is planned when the data become available.

Looking at the issue from a different perspective, Victor and Vetter[151] used 1980 G.H.S. data to see if the health and social services discriminated in favour of the poor and disabled. 56% of the elderly were found to be living in poverty (defined as having income up to 40% above the supplementary pension scale rate). There was no significant difference in service use between the "poor" and the "not poor". When their degree of disability was taken into consideration, no substantial difference in contact rates were observed between the "poor" and "not poor" for health services (except the district nursing service for the severely disabled). But for the social services, especially home helps, the higest usage rates were found in the "not poor". The authors concluded that neither health nor social service departments, for a given level of disability, discriminate in favour of the poor.

In 1984 two studies using the same data source came to very different conclusions about use of services. One inferred from the results that doctors were discriminating in favour of occupational class V patients. The other study put a completely different interpretation on the findings. Using the national morbidity survey of general practice Crombie[143] investigated consultation rates by dividing them into two groups: first-time consultations initiated by the patient and repeat appointments initiated by the doctor. In the ones initiated by the patients, lower occupational classes had fewer consultations for preventive services than higher classes but more consultations for acute

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

episodes like accidents and violence, so that overall there was little difference in consultation rates between the classes. However, for repeat consultations initiated by the doctor, Crombie noted that occupational class V patients had more consultations for a given episode of illness. He reasoned that doctors were compensating for lack of coping skills in class V patients by giving them more return appointments. Blaxter[141] looked at what conditions the patients were consulting their doctors about. She also found higher consultation rates for occupational classes IV and V, but concluded that these higher rates were justified by the more severe nature of the illness they experienced. The lower occupational clases had more illness which was more life-threatening and more painful in nature than higher classes. These two studies illustrate clearly the difficulty of interpreting research in the health service field.

Bucquet and Curtis (1986)[32] report a community survey of three London Boroughs using the Nottingham Health Profile to compare self-reported morbidity with service use by manual and non-manual classes. The study also aimed to identify which types of morbidity were likely to trigger a consultation and which were not. There were substantial differences in the prevalence of ill-health between social groups. The manual groups were particularly susceptible to tiredness, sleep disturbance, pain and emotional distress. However their higher levels of morbidity were not matched by higher consultation rates for these conditions.

A detailed local study in general practice has recently tackled the issue of deprivation and health in one practice serving 15,500 patients. Marsh and Channing (1984)[146] selected a sample of 587 "deprived" patients from their register and these were paired with matched controls from a "more endowed" area. Data on patients for ~~the~~ previous 3-5 years were abstracted for analysis. Deprived patients were found to have 60% more hospital admissions, 75% more casualty attendances, and almost three times as much mental illness as the control group. Comparisons of serious physical illness, consultant referrals and G.P. consultations all showed the same trend. There was significantly more non-attendance for appointments and much worse immunisation rates and other preventive care in the deprived group. In total, the deprived patients had provided a 50% higher morbidity load to the health services than their matched controls. Marsh and Channing go on to describe what a practice can do in practical terms to try to improve the health of its deprived patients.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

SECTION 5

INTERNATIONAL COMPARISONS

5.1 Mortality Comparisons

There are still great difficulties in comparing statistics from different countries. Macfarlane and Mugford[42] have reviewed in detail the problems in perinatal and infant mortality comparisons; Blaxter[26] has done the same for measures of inequality in morbidity, Macintyre[152] for health service comparisons in Europe, and Lynge[153] has dealt with the problems of estimating mortality differentials.

Table 8 shows mortality from all causes in selected countries around 1983[154]

Table 8

MORTALITY FROM ALL CAUSES IN SELECTED COUNTRIES, LATEST AVAILABLE YEAR AROUND 1983

	Expectation of life at birth		Death rate/1000 population in selected age groups					
			Age under 1 year		Age 20-24		Age 55-59	
	Male	Female	Male	Female	Male	Female	Male	Female
England and Wales	71.34	77.3	11.4	9.0	0.8	0.3	13.2	7.4
Scotland	69.3	75.4	12.8	9.7	1.0	0.3	17.5	9.4
Northern Ireland	69.2	75.6	15.0	12.4	1.2	0.6	14.0	8.9
Denmark	71.5	77.5	8.7	6.4	1.1	0.4	13.2	7.9
Finland	70.1	77.9	6.6	5.9	1.1	0.4	15.6	5.8
Iceland	73.9	79.4	5.4	7.0	1.1	0.5	12.4	5.2
Norway	72.6	79.5	8.7	6.9	1.2	0.3	11.2	5.4
Sweden	73.6	79.6	7.0	7.0	1.0	0.3	10.0	4.8
France	70.4	78.4	12.3	9.0	1.8	0.6	13.8	5.4
Netherlands	72.7	79.4	9.3	7.5	0.8	0.4	11.2	5.4
Hungary	65.5	79.4	21.3	16.4	1.6	0.5	22.7	10.1
U.S.A.	71.0	78.3	12.7	10.2	1.5	0.5	13.8	7.3
Japan	74.2	79.7	6.8	5.6	0.9	0.4	9.1	4.4
Bangladesh	55.3	54.4	128.4	119.5	1.6	2.9	21.2	21.8
Nepal	46.6	45.1	Not available		Not available		Not available	

Source: United Nations Demographic Yearbook for 1984[154]

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Several points are illustrated by the table:

1. In all developed countries female life expectancy is greater than that of males by several years. Nepal and Bangladesh have been included to illustrate a common characteristic of developing countries, where the sex differential is reversed and males can expect to live longer than females.

2. Death rates are lower for women than for men at each stage in life in developed countries. In countries like Bangladech high maternal mortality in child-bearing years contributes to higher death rates in women at these ages.

3. England and Wales still compare unfavourably with the Nordic countries on infant mortality, but have a better record than many on deaths in early adulthood. The country's record deteriorates again for deaths in late middle-age. Scotland and Northern Ireland compare even more unfavourably with most European countries.

4. The pattern differs for each country. For example, Finland has had an excellent record on infant health for several years, but a poor record with respect to the middle-aged and older men in the population. Japan comes out favourably at all stages of life. Hungary consistently comes out badly in comparison with other developed countries.

Macfarlane and Mugford(42) conclude from their analysis of international comparisons that at least as far as perinatal mortality is concerned, the performance of England and Wales in the 1980's is not quite as bad as some observers have suggested. Nor would the U.K. countries be "near the bottom of the league" if there was a uniform international classification.

Catford and Ford (1984),(155) however, draw attention to our much poorer record on premature mortality in men and women aged 45-64. From a comparison of 12 European countries in 1980 they concluded that mortality was considerably higher in the U.K. than elsewhere. This applied to circulatory and respiratory diseases, cancer, and "all causes". They point out that our relatively low mortality from accidents reduces the overall mortality difference, but it is still striking. Comparing mortality from all causes in 1950 and 1980, they concluded that France and Finland made notably better advances in health than the U.K. countries for this age group.

5.2 The extent of inequalities

The above statistics, of course, do not say anything about the extent of the inequalities in health within each country. Different countries use different social variables to measure inequalities: occupation; income; education; social circumstances; rural/urban residence and so on. But however inequality is measured, every country is found to have disadvantaged and advantaged groups which differ in their experience of health.(160)

Inequalities between social groups show up in most countries when chronic disease and limiting long-standing illness are measured.

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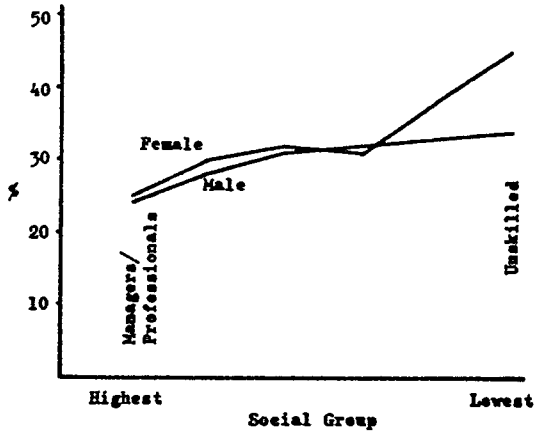
Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Blaxter(26) notes that in middle-age men rates of chronic diseases are commonly 40-50% higher in the lowest compared to the highest social groups.

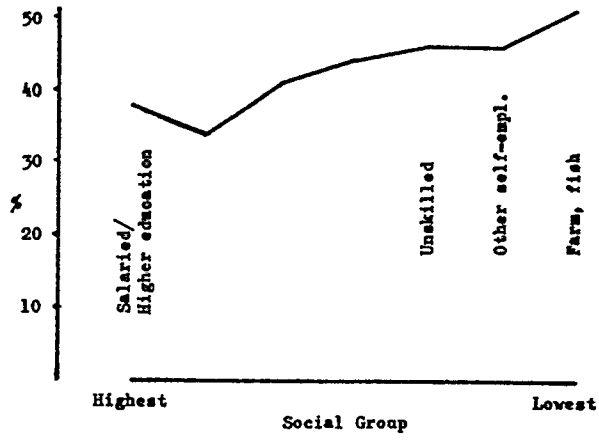
Figure 13 illustrates inequalities in chronic illness from studies in five European countries.

Figure 13

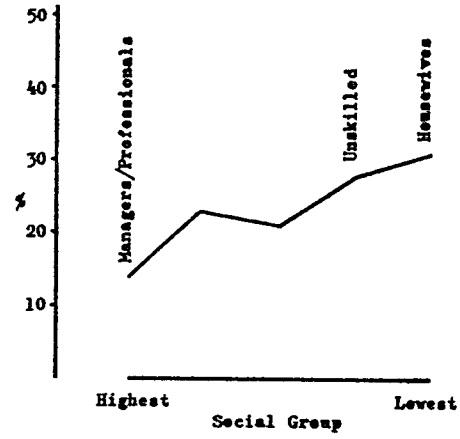
Some examples of social trends in chronic illness



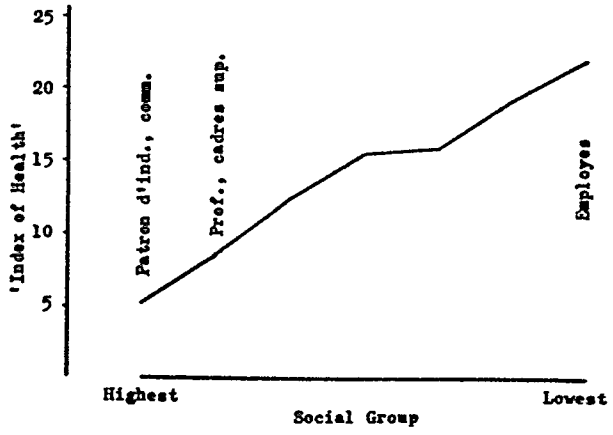
Britain - per cent with chronic illness
G.H.S 1983



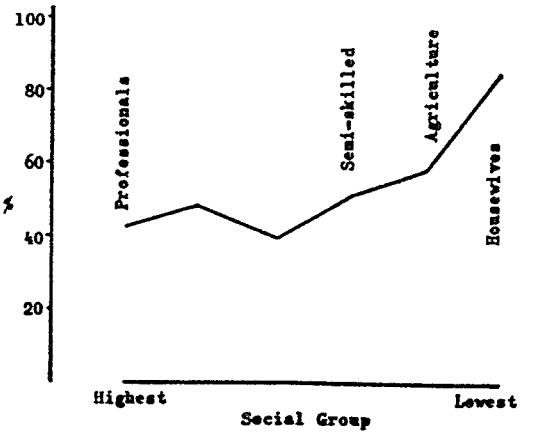
Norway - per cent with chronic illness
Level of Living Survey 1980



Denmark - per cent with chronic health problems
Nat. Inst. Soc. Res. 1979



France - 'Index of Health'
Boulogne-Billancourt Survey 1972



Hungary - per cent of 'unhealthy people'
Zala County Survey 1979

Source: Blaxter (1987) see ref. 26

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Low income is also commonly associated with poorer health particularly for chronic illness and disability in middle-age. Table 9 illustrates how rates of chronic illness vary with income in Finland, France, Norway and Hungary.

Table 9

Examples of Morbidity variation by income

Finland	% with chronic illness	
	Lowest income group	Highest income group
Urban communes	42	18
Rural communes	49	27
	(Service Use and Health Status 1974)	

France	% with chronic illness	
	Lowest income group	Highest income group
	57.2	30.5
	(INSEE-CREDOC Survey 1970)	

Norway	% with chronic illness	
	Lowest income group	Highest income group
	52	39
	(Level of Living Survey 1980)	

Hungary	% "unhealthy", age 31-50		
	Poor	Middle Level	Well to do
Urban	62	54	35
Rural	89	63	
	(Country of Zala Survey 1979)		

Source: Blaxter (1987) reference(26)

In the USA the association between income and mortality has also been investigated in an important cohort study, the Alameda County Study in California.(156,157) The study has been assessing levels of health in the sample and trying to determine factors associated with health since 1965. When family income was studied those with "inadequate" income had much poorer survival chances over 18 years of follow-up. For example, compared to the richest

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

group, the poorest group had more than double the risk of death over 18 years. The study went on to analyse whether harmful behaviour patterns accounted for the increased risk. Even when the data were adjusted to take account of 13 known risk factors including smoking, drinking, exercise and race, there was still a substantial gradient of risk associated with income. For example, the poorest group still had 1½ times the risk of death as the richest group. They concluded that behaviour patterns were not the major factors related to the increased risk of death and suggested that factors related to the general living conditions and environment of the poor were more likely to be implicated. This line of enquiry is continuing. The same study also looked at the three-way links between race, income and health. Blacks were found to have significantly poorer survival chances than whites, but when adjustments were made for level of family income the difference between the two groups reduced and was not statistically significant.

5.3 Comparative studies

A number of recent studies have tried to compare several countries in relation to social inequalities in health.

Valkonen (1987)[158] for example compared mortality by level of education in Denmark, England and Wales, Finland, Hungary and Norway in the 1970's and 1980's. Death rates were found to decline with increasing years of education with a remarkably similar pattern in all six countries. Changes in inequalities over the decade were also analysed. Educational inequalities in mortality in both men and women had clearly increased in England and Wales in the 1970's. There was no change in mortality in the lowest educational category, whereas there was a decline of between 10-20% in the other categories. No significant increases in inequality were noted for the Nordic countries over the same period.

Andersen et al (1987)[159] compared occupational mortality in the 4 Nordic Countries from 1971-1980, making use of compatible census-linked longitudinal studies. Standardised mortality ratios were based on the whole Nordic population in paid employment.

Table 10 shows SMRs for "all causes" for men and women in and out of paid employment. From the table, for employed men Finland had by far the highest mortality, followed by Denmark, then Norway, with Sweden having the lowest. For employed women, Denmark had the highest mortality with Finland near the average, followed by Norway and Sweden below average. For both men and women in all 4 countries those out of paid employment had much higher mortality than those in employment. (Those out of paid employment included the economically inactive and the longer-term unemployed).

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Table 10

MORTALITY OF ADULTS IN AND OUT OF PAID EMPLOYMENT IN THE FOUR NORDIC COUNTRIES 1971 - 1980 (aged 20-64 in 1971)

Males	In paid employment Standardised Mortality Ratio	Out of paid employment Standardised Mortality Ratio
Denmark	104	247
Finland	133	283
Norway	92	223
Sweden	88	200
All	100	233
Females		
Denmark	120	167
Finland	102	172
Norway	89	130
Sweden	93	142
All	100	151

In paid employment = economically active persons, including short-term unemployed.
Out of paid employment = economically inactive persons, including longer-term unemployed (over 4 months).
(SMR for all economically active persons in all Nordic countries = 100)
Source: Andersen, O. et al (1987) See Reference 159.

Table 11 shows SMRs for a range of occupational groups. Clear differentials in mortality in men from different occupational groups can be seen. Finnish men again had the highest mortality in almost every occupational group, with Norway and Sweden comparing favourably. It is noticeable that the same groups were advantaged and disadvantaged in all 4 countries. Thus non-manual groups (particularly teachers, nurses and medics), had relatively low mortality, while manual groups (particularly deck and engine room crew and hotel and domestic workers) had high mortality.

When causes of death were investigated in the study it was found that groups with high mortality overall had very high mortality for all causes of death, not just for a few specific occupational hazards.

It has been suggested that those countries with the greatest inequality of income tend to have the greatest health inequality.[26] Part of the success of the Netherlands and Sweden in reducing inequality in health between social groups has been attributed to their more universal "affluent" life-styles, though there is very little, if any, new evidence on this.[160] Cereseto and Waitzkin (1986)[161] have compared a measure of the "Physical Quality of Life" in 123 capitalist and socialist countries and found that the socialist countries came off best on this scale. As yet this is an isolated finding which would need confirmation with other studies.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Table 11

MORTALITY OF SELECTED OCCUPATIONAL GROUPS IN THE 4 NORDIC COUNTRIES 1971 - 1980

Occupational group	Country			
	Denmark	Finland	Norway	Sweden
	SMR	SMR	SMR	SMR
Men Low mortality occupations				
Technical work	91	100	69	74
Medical and nursing work	96	118	81	85
Pedagogical work	76	83	65	65
Men High mortality occupations				
Deck and engine room crew	193	191	151	161
Packing, labelling, dock work etc.	121	156	112	107
Hotel, restaurant and domestic work	178	194	130	138
Women Low mortality occupations				
Technical work	116	103	89	93
Medical and Nursing	113	85	79	86
Pedagogical work	104	78	73	76
Agricultural work	91	98	79	85
Women High mortality occupations				
Road transport work	128	113	101	105
Hotel, restaurant and domestic work	132	110	100	93

Standardised Mortality Ratio (SMR) for all economically active persons in the 4 countries = 100

Source: Andersen, O. et al (1987) See Reference 159.

5.4 Policies for reducing inequalities in health

- The Finnish experience

Detailed reports on inequalities in health and health care have recently been prepared for Finland[162,163] and these give insight into practical policies for reducing inequalities.

In 1964 there were considerable regional differences in the frequency of consultation with doctors in the state-subsidised health care system. Residents in the "healthier" south of the country made more use of doctors' services than those in the "less healthy" East and North. However, between then and 1976 these regional differences had diminished, especially among those who were chronically sick, and the relative differences are now said to be negligible in the rural areas and much reduced in the urban areas.[162]

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

What is perhaps even more surprising is the reduction in regional differences in mortality over the same period. Differences between cities and rural areas in mortality rates of men aged 35-75 are said to have disappeared. Among women there were no evident differences anyway. There is still a differential among some of the provinces, though, and large differences still persist in the use of the private dental services.

The reduction in regional differentials has been attributed to the very active policy-making which was adopted to combat inequalities.(162) It was recognised that there was an unfair geographical distribution of medical personnel, and an Act of 1972 enforced a two-pronged strategy:

(a) Health resources were preferentially allocated to Northern and Eastern parts of the country. Cities which had hospitals and health centres were deliberately left lagging behind. Subsidies were offered to set up new medical posts in priority areas. Higher salaries were offered in community health centres than in the hospital sector.

(b) Building costs were switched from hospital to health centre buildings. By 1981 the community and hospital sector were taking equal shares of the building budget (formerly the hospital sector took the major share).

The policy seems to have been successful because the health centres in rural areas in Lapland and Eastern Finland "are today better manned than those in the big cities." There has been a corresponding improvement in the number of nurses and dentists in the priority areas too.

Finland also has an excellent record in reducing the proportion of low-birth-weight babies and consequently reducing perinatal and infant mortality. Even up to the early 1970's Finland's rate of low birthweight babies was considerably higher than that of Sweden. Over the last decade it has been reduced to one of the lowest levels in Europe. To what do they attribute this success? The Black Report outlined the rapid development of primary health care services in Finland which aimed to cover a large proportion of the population with out-reach programmes. Since then further improvements have been made. Koskinen et al(162) point out that the WHO Health for All targets have been adopted enthusiastically. Finland has a target of reducing the number of low birthweight infants to less than 3% by a set date, and to this end, new social maternity benefits for all pregnant and nursing mothers have been introduced in the 1970's. By 1982 all women were entitled to 258 days of paid maternity leave (compared to 72 days in 1971), and men were entitled to 6-12 days of leave around the time of birth, and between 25-100 days paternity leave in exchange for some of the maternity leave (compared to nil in 1971). 20% of men take advantage of this benefit.

What has still to be tackled in Finland, though, is the inequality in the use of health services by different income groups. The frequency of consultation with doctors increases with increasing income, when adjustments are made for the variation in the number of days sick. Hospital use has a U-shaped association with income.(162)

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

5.5 Conclusions

So what conclusions can be drawn from these international comparisons? Certainly the U.K. is not alone in experiencing inequalities in health. Every country to a greater or lesser extent experiences differences in health between regional, social or income groups. The question of whether some countries have less inequality in health than others is very difficult to answer. It has been widely suggested that Sweden and the Netherlands have managed to greatly reduce inequalities since the 1950's and this has been attributed to affluent life-styles more evenly distributed among the population. However, it is difficult to get firm evidence on what has caused the reduction in inequality, and it is evident that in adults some inequality still remains.

A remarkably similar pattern of inequality in health was found when mortality by level of education was investigated in 6 European countries. The study confirmed earlier findings in this country, that death rates decline with increasing years of education. What was disturbing from the same study was the suggestion that educational inequality in health had increased in the 1970's in England and Wales more than in the Nordic countries.

What is instructive from these comparisons are the examples of concrete strategies which have been adopted to reduce specific inequalities. The Finnish example of reduction in regional (particularly rural/urban) variations in health and health care is illuminating. The findings from the major study in Alameda County, California have implications for the debate in the U.K. on explanations of health inequality (see section 6).

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

SECTION 6

EXPLAINING HEALTH INEQUALITIES

Of crucial importance is the question of how health inequalities are generated and maintained. The Black Working Party examined the evidence on causes of occupational class differences in health under 4 main headings: artefact, health selection, cultural/behavioural and materialist/structuralist explanations, Material and structural factors were judged to be the main contributors to inequalities, though the other explanations were not mutually exclusive and could be seen to play some part at varying stages of life.

This section looks at fresh evidence published since 1980 which has taken the discussion forward. Useful reviews are available by Blane (1985)[164] Wilkinson (1986)[117] and Macintyre (1986.[13]

6.1 The artefact explanation

This approach, described in depth by Illsley (1986),[118] and Jones and Cameron (1984),[165] suggests that the method of measuring occupational class - by the Registrar General's social class classification -artificially inflates the size and importance of mortality and morbidity differentials. The authors maintain that the Registrar General's classification and the nature of occupations open to the labour force have changed so much in recent decades that any comparison with earlier decades this century are meaningless using this classification as a tool. The arguments and evidence concerning this explanation have already been outlined in greater detail on pages 37 and 38. Briefly, the recent evidence continues to point to very ~~real~~ differences in health between social groups which cannot convincingly be explained away as artefact. On the contrary, the work of Rose and Marmot in the Whitehall Study[23,24] and Lynch and Oelman[25] on the Army sample suggest that the Registrar General's classification may under-estimate the size of the social class gradient in health. The work of Marmot and McDowall[20] comparing two large classes which make up the bulk of the working population, not a small minority, still found inequalities in health which had widened over the last decade.

The consensus is that the use of occupational class, though a crude tool, is still valid with careful use of the data.

The argument that we could do with a better measure of social class than one based on occupation is widely accepted.[21,120,12] Occupation is just one of the many inter-related factors which contribute to the concept of social class. For instance Osborn and Morris[12] point out that there is a tendency for some social groups to be realtively privileged in almost every respect - power, status, income, education etc. - and for other groups to be relatively disadvantaged in almost every respect. That the disadvantaged groups have poorer health than the privileged groups is at the heart of the studies in inequality.

Occupational class is used as a proxy for social class quite simply because it is easier to measure and use than a compound index.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

However, in studies which have used other indicators of social circumstances (like income, housing tenure, Social Index, household possessions) inequalities in health have uniformly been detected. There can be no doubt that these inequalities exist however imperfect the measuring tool.

6.2 Theories of natural and social selection

Explanations in terms of selection accept that social inequalities in health exist, but suggest that the differences are caused by a health selection process. According to this explanation, people in poor health would tend to move down the occupational scale and concentrate in the lower social classes, while people in good health would tend to move up into higher classes. The gap between the health of the higher and lower classes would therefore be kept open indefinitely and would be inevitable whatever overall improvements in health occur over the entire population.

Has any new evidence shed more light on this explanation? Illsley[118] has presented new data for the three decades from 1951 to 1980 which confirm his early studies on first-time mothers in Aberdeen and the outcome of their pregnancies. There was a gradient in perinatal mortality, birthweight and height of mothers between the occupational classes. It was noted that taller women tended to move up the occupational classes at marriage, whilst shorter women tended to move down at marriage. As height can be taken as an indicator of health before marriage, this evidence shows that some sort of health selection was taking place at marriage and contributing to the class differential.

The 1980 OPCS survey of heights and weights in Great Britain[37] confirmed that the "shortest women were least likely to raise their social class through marriage and that, to a lesser extent, the tallest were most likely to raise their social class in this way." However OPCS were less certain about what interpretation to put on these findings.

Wilkinson[119] has recently tried to estimate how large the health selective effect was from Illsley's data. He calculated that the amount of selective movement between classes indicated by height and education data, accounted for little more than 10% of the observed social class gap in perinatal mortality rates. The bulk of the differential, he concluded, must be due to other influences.

Stern (1983)[166] has produced a theoretical model showing that it would be possible to create the observed occupational class differential in health through social mobility provided that health selection was a major determinant of social mobility. However, evidence from social mobility studies[167,168] suggests that the main determinants of social mobility are education and material and cultural background of the family rather than health.

Wadsworth (1986)[80] using data from the National Survey of Health and Development cohort study, has shown that serious illness in childhood can affect social mobility. Whatever their class of origin, seriously ill boys were more likely than others to experience a fall in occupational class by the time they were 26.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Wilkinson (1986)[117] has attempted to estimate the contribution this downward mobility due to childhood illness would make to the observed adult class differential. He calculated that "only about 1.5% of those seriously ill in adulthood had suffered downward mobility as a result of serious childhood illness."[117] Preliminary results from Power et al (1986)[169] also confirmed that some social mobility in childhood was related to health, but this mobility did not account for the social class gradient in health observed.

Fox et al (1986)[18] have used the Longitudinal Study data to examine health-related selection in older adults. They concluded that for men over 50 years of age selective health-related mobility between social classes did not contribute to the mortality differentials.

In the Whitehall Study the men were given a rigorous medical examination on entry to the study. In the group of men without any detectable disease at the beginning of the study, a steep mortality gradient between grades was observed at death. Recruitment of sicker men into lower grades in the civil service would not explain the gradient in this case.[24]

To sum up, there is some new evidence that health selection operates at younger ages, and new evidence for men over 50 that no such selection effect is evident after this age. Estimates of the size of the selection effect suggest that it accounts for only a small proportion of the overall differential between the social classes.

6.3 Cultural/behavioural and materialist/structuralist explanations

The health selection explanation suggests that health can determine subsequent social position. The third and fourth explanations both take the view that social circumstances can affect subsequent health, but differ in where they put the emphasis.

The cultural/behavioural explanation stresses differences in the way individuals in different social groups choose to lead their lives: the behaviour and voluntary life-styles they adopt. In this explanation inequalities in health evolve because lower social groups have adopted more dangerous and health-damaging behaviour than the higher social groups, and may have less interest in protecting their health for the future.

The structuralist/materialist explanation emphasizes the role of the external environment: the conditions under which people live and work and the pressures on them to consume unhealthy products. Inequalities in health in this context would come about because lower social groups are exposed to a more unhealthy environment. They do more dangerous work, have poorer housing, and have fewer resources available to secure the necessities for health and to use the available health services. At a more general level, the whole structure of society is implicated.

But several commentators[164,160,117] are beginning to question whether the distinction between the two approaches is artificial, as behaviour cannot be separated from its social context. Blaxter[160] quotes the classic example of childhood accidents to illustrate the point. The observation that children from lower social groups have more accidents than children from higher groups may be explained by

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

the behavioural view as due to more reckless risk-taking behaviour in this group and inadequate care by parents. The materialist view would highlight the unsafe play areas, the lack of fenced-off gardens, and the greater difficultly of supervising children's play from high-rise housing. In the latter view the environment is dictating the behaviour of both mother and child.

The following new evidence supports the behavioural and the structural/materialist explanations and shows how the two are inter-related.

6.4 Evidence on cultural/behavioural differences

Latest evidence confirms previous observations that there are life-style differences between the social classes which are related to health. Cigarette smoking would be a prominent example.

6.4.1 Smoking habits

Table 12 gives the percentages of cigarette smokers in each socio-economic group over the period 1972 to 1984.(28) It is clear that in every year the percentage of smokers increased steadily from the professional group through to the unskilled manual group. For example in 1984 17% of professional group men and 15% of professional women were smokers compared to 49% of men in the unskilled manual category and 36% of unskilled manual women.

Table 12

Prevalence of cigarette smoking by sex and socio-economic group: 1972 to 1984

*Persons aged 16 and over** — *Great Britain*

Year	Socio-economic group†						
	Professional	Employers and managers	Intermediate and junior non-manual	Skilled manual and own account non-professional	Semi-skilled manual and personal service	Unskilled manual	All aged 16 and over
	Percentage smoking cigarettes						
Men							
1972	33	44	45	57	57	64	52
1974	29	46	45	56	56	61	51
1976	25	38	40	51	53	58	46
1978	25	37	38	49	53	60	45
1980	21	35	35	48	49	57	42
1982	20	29	30	42	47	49	38
1984	17	29	30	40	45	49	36
Women							
1972	33	38	38	47	42	42	42
1974	25	38	38	46	43	43	41
1976	28	35	36	42	41	38	38
1978	23	33	33	42	41	41	37
1980	21	33	34	43	39	41	37
1982	21	29	30	39	36	41	33
1984	15	29	28	37	37	36	32

* *Aged 15 and over in 1972.*

† *Members of the Armed Forces, persons in inadequately described occupations, and all persons who have never worked have not been shown as separate categories. They are, however, included in the figures for all persons.*

Source: General Household Survey for 1984 see ref. 28

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

The table also shows that there has been a decline in smoking prevalence in most socio-economic groups, but the decline has been more rapid in some groups than in others. For example, prevalence in women in the manual groups has shown very little reduction over the decade, whereas that in the professional group has shown a pronounced decline.

Smoking habits varied with economic status too. For example, in 1984 36% of men in work were smokers, compared to 61% of unemployed men. The corresponding figures for women were 34% and 48%.(28) Table 13 gives an indication of the regional variations in smoking in 1984(28) (although the data have not been standardized for age.)

Table 13

Prevalence of cigarette smoking by region*

Persons aged 16 and over — *Great Britain: 1984*

Region	Percentage smoking cigarettes	*Base = 100%*
England		
North	36	*1020*
Yorkshire and Humberside	39	*1662*
North West	35	*2133*
East Midlands	31	*1334*
West Midlands	33	*1791*
East Anglia	24	*651*
Greater London	37	*2090*
South East	31	*3415*
South West	30	*1383*
Wales	37	*925*
Scotland	39	*1801*

* *It should be noted that the data in this table have not been standardised to take account of differences in age-structure between regions.*

Source: General Household Survey for 1984 see ref. 28

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Class trends in mortality from lung cancer and coronary heart disease show some similarity to the smoking trends. Thus there is a social class gradient in mortality for both diseases with lower rates in the professional classes to highest in the unskilled manual class. In addition mortality over the decade has been declining faster in non-manual groups than in manual groups as Fig. 9 on page 39 has already illustrated.(20)

Mortality from lung cancer and coronary heart disease is higher in the unemployed than in the employed population, and regional variations in mortality from the diseases mirror the smoking variations to a certain extent.

In the case of coronary heart disease there are further similarities. Before 1950 mortality from the disease in men was marginally higher in Class I and II than in IV and V, but during the 1950's the gradient reversed and mortality became higher in classes IV and V than in I and II.(170,171)

Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

6.4.2 Alcohol

Drinking habits vary between the social groups too, but in a much more complex way. Heavy drinking is more common among manual groups than among non-manual groups. For example, 26% of unskilled manual group men were classed as heavy drinkers in 1984, compared to 8% of professional men.(28) At a regional level the highest proportion of heavy drinkers was found in the North (including the North East) and Wales, and the lowest in East Anglia and the Outer South East of England.(28) However, the pattern varied considerably in relation to other categories of drinker. For example, the unskilled manual group had the highest percentages of abstainers as well as the highest percentage of heavy drinkers. This group also had a lower proportion of "frequent light drinkers", whereas the professional and managerial groups, both men and women, had the highest proportion of this type of drinker. Which pattern of drinking would ultimately be more detrimental to the health of each group is debatable. There is some evidence that mortality from chronic liver disease and cirrhosis was lower in class I men and high in class V men in 1979-83,(17) but apart from that the situation is unclear.

6.4.3 Food and nutrition

There are differences between social groups in the quantity and nutritional quality of the food they eat. In this context comparisons are made between income groups. Group A to D represent households with at least one earner. Group A contains the richest 10%, group D the poorest 10% and groups B and C are intermediate, each representing 40% of households with one earner.(172) Table 14 shows consumption of some of the main food categories by income group in 1976 and 1984. It is interesting to note how the pattern has changed over that period, bearing in mind that recent nutritional advice has stressed the need to eat more fibre (e.g. in bread, particularly brown and wholemeal), more fresh fruit and vegetables including potatoes, and to cut down on sugar, salt and fat, particularly animal fat. In both years the richest group consumed more brown and wholemeal bread, more fresh fruit and vegetables and less white bread, potatoes, sugar and fat than the poorest group. By the mid-1980's all income groups had increased consumption of brown and wholemeal bread and potatoes and cut down on sugar. (By 1986 brown and wholemeal bread accounted for 25% of all bread consumed compared to 10% in 1976.(296)) However, consumption of fresh fruit and vegetables had increased only marginally in groups A, B and C, and in the poorest group had actually declined. There was a small reduction in the consumption of total fats across all income groups, but a substantial change in the type of fats consumed. Butter, lard and compound cooking fat consumption declined markedly and there was a corresponding increase in margarine and "all other fats" consumption in all income groups. Thus in terms of the food-stuffs listed, the richest income group continues to have a healthier diet than the poorest group. However, there are signs that within the limits of their income, the poorest group may have responded to nutritional advice to the same extent as other groups, for example in wholemeal bread consumption. How much the poorest group's choice of food is restricted by low income is discussed in greater detail on pages 71-73.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Table 14

Food Consumption by income group, Great Britain, 1976 and 1984
(oz./person/week

FOOD

Income Group	White Bread		Brown Bread incl. wholemeal		Sugar		Total Fats		Fruit (fresh)		Vegetables (fresh)		Potatoes	
	1976	1984	1976	1984	1976	1984	1976	1984	1976	1984	1976	1984	1976	1984
A	19.8	12.3	4.1	8	12.3	8	9.8	9.1	22.5	25.3	27.3	30.7	29.8	33.4
B	26.2	18.3	3	6	13.4	9.4	10.5	9.5	18.3	19	24	24.4	35	36.5
C	30.4	23.0	3	5.9	14.5	10.9	11	10.4	15.2	16	24.8	25.5	38.2	42.4
D	29.9	26.0	2.7	5.2	15.7	11.5	11	10	15.2	13	24.9	21.5	42.3	48.3

Source: MAFF: Household food consumption and expenditure for 1976 and 1984. References 172 and 173.

There is also evidence of higher consumption of sweets by children ~~in~~ lower social groups.(202)

The links between nutrition and health are many and varied, ranging from effects on growth to links with specific diseases like coronary heart disease and obesity, to general resistance to infections, most of which are also class-related.

6.4.4 Exercise in Leisure-time

Data on leisure-time activities by socio-economic group were available in the 1973, 1977 and 1983 General Household Surveys.(27) Table 15 shows two of the most popular activities: walking and swimming. In both, the professional group had the highest participation rates and unskilled manual the lowest. There was an increase in participation from 1977 to 1983 for all groups, but the social gradient remained.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Table 15

Exercise in leisure-time in Great Britain by socio-economic group. Persons aged 16 and over. 1977 and 1983

% participating

Socio economic group	Walking (over 2 miles) 1977	1983	Swimming 1977	1983
Professional	29	30	11	18
Employers & Managers	23	24	9	14
Intermediate - Non-manual	27	27	10	15
Junior - Non-manual	20	22	7	14
Skilled manual	15	16	6	8
Semiskilled manual	12	15	3	6
Unskilled manual	10	13	3	5

Source: General Household Survey for 1977 and 1983.

Exercise may be linked to health in several ways, including a possible protective effect against coronary heart disease -mortality from which is, of course, class related.(174)

Poorer take-up of preventive services by lower social classes has already been noted; it is clearly a possibility that this is due to cultural norms and voluntary behaviour choices rather than to material barriers to take-up, such as limited access.

The evidence outlined above suggests that differences in life-style can indeed account for some of the class differential in health, but how much of it do the life-style factors account for? A more systematic investigation of coronary heart disease risk factors was carried out in the Whitehall Study.(24) The two major smoking-related diseases, coronary heart disease and lung cancer, were related both to smoking and employment grade. 29% of the top grade were smokers, compared to 61% of the bottom grade. However, it was found that even

Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

for non-smokers coronary heart disease was strongly associated with grade. Table 16 shows what happened to the class gradient for coronary heart disease when controlled for age, smoking, systolic blood pressure, plasma cholesterol, height and blood sugar. The risk associated with employment grade reduced by less than one quarter. Likewise controlling for exercise in leisure-time had little effect on the differential. In addition, steep gradients were found for diseases thought not to be related to smoking.

Table 16

RELATIVE RISK* OF CHD DEATH IN 10 YEARS CONTROLLING FOR (A) AGE, AND (B) AGE, SMOKING, SYSTOLIC BLOOD PRESSURE, PLASMA CHOLESTEROL CONCENTRATION, HEIGHT AND BLOOD SUGAR

	Administrators	Professional/ executive	Clerical	Other
(a) Controlling for age	1.0	1.6	2.2	2.7
(b) Controlling for other risk factors	1.0	1.5	1.7	2.1

* Calculated by multiple logistic regression.

Source: Marmot, Shipley and Rose, The Lancet (1984) See Reference 24.

The work of Cook et al[53] on unemployed and employed groups has already been described on page 21. Excess mortality in the unemployed group was still evident when the study controlled for smoking and drinking. The Alameda County Study (page 54) also concluded that behaviour patterns were not the major factors responsible for the class differential. The suggestion from these studies is that there are other environmental factors contributing to the health differential in addition to the more specific behavioural ones.

Several new studies have touched on the cultural aspect of this explanation - the suggestion that beliefs about health and health care may differ among social groups. The "culture of poverty" idea-that poorer groups have more negative concepts of health and a lack of orientation towards the future which inhibits preventive health action - has been re-examined. For example, Calnan and Johnson (1985)[175] compared the health beliefs of women from social class I and II with those of social class IV and V on two issues: concepts of health and perception of vulnerability to disease. Both of these issues are claimed to be reatled to decisions to take action on health. Findings showed that there was no social class difference in theories about vulnerability, or in concepts of health when defined in relation to personal health.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Only when health was defined in the abstract was there marked social class differences and this may have been because middle-class women found it easier to express abstract ideas.

Similarly Blaxter and Paterson (1982)[176] in a study of disadvantaged mothers and daughters in Scotland found no evidence that would fit a simple "culture of poverty" model in either generation. Problems in health service use in the younger generation seemed to stem more from a lack of skill in dealing with the system rather than from adverse cultural beliefs. These and other studies[213,214] suggest that the importance of the "culture of poverty" model as an explanation of poor service use and health-damaging behaviour may have been over-estimated in the past, and new appraisals of health behaviour are needed.

6.5 Evidence that material factors affect health or health-related behaviour

A number of studies published recently have investigated how material and structural factors affect health. Others have looked at how such factors influence behaviour or limit choice about health.

6.5.1 Housing conditions and health

Housing inequalities have been extensively reviewed by Murie (1983).[177] This subject has been badly neglected until recently and is only beginning to be studied again, mainly in the public sector.

Keithley et al (1984)[178] carried out a study in Gateshead in 1983 on 8 council housing areas, from the very best to the very worst in the area. Controlling for age, there were marked and consistent differences in self-reported health between individuals from different areas. People from "bad" housing areas reported poorer health, more long-standing illness, more recent illness and more symptoms of depression than "good" housing areas. The position was reversed for the over 65's because of a local authority lettings policy which gave priority to the less fit elderly. Nearly a third of households reported defects in houses which they thought affected health, and these disproportionately came from the three "bad" areas, especially in connection with respiratory conditions. "Bad" council housing areas did not necessarily conform to the stereotype of non-traditional construction and high-rise flats. Location, poor environment and low quality of construction were the important factors.

A further paper by the same team[179] looked at respiratory conditions in council housing tenants in greater detail. It was found that smoking, unhealthy working environment and age were the most important determinants or respiratory problems. When these were held constant people in areas of "bad" housing reported more respiratory conditions than those in "good" housing areas. The problems were associated with flats rather than houses, and with older accommodation.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Coleman (1985)[180] in a large scale study, investigated whether the design of buildings could lead to social malaise among the inhabitants. The study covered over 4,000 blocks of flats and 4,000 houses in London with additional information from around the country and abroad. 15 design variables in blocks of flats were identified which affected the behaviour of at least some of the residents, especially children. The degree of social malaise was indicated by the extent of litter, graffiti, vandalism, children taken into care, urine and faecal pollution. Circumstances worsened as buildings and grounds became bigger, as the amount of inter-connecting walkways increased and also where residents could not see or control the approach to their dwellings. The study concluded that such badly-designed blocks "made it difficult for normal people to cope", and thus contributed to social malaise.

Young (1980)[181] examined the growing problems of infestation of housing estates with the associated health risks. He details how the design of the high-rise buildings with their inter-connecting ducts and heating systems allows rapid spread of vermin, over which spread the individual tenants have very little, if any, control.

An analysis of "difficult to let" council housing in Liverpool[182] concluded that the unsatisfactory housing conditions were contributing to high rates of infectious diseases, respiratory disease, and mental illness on one estate. One source of infection was traced to unhygienic mobile food vans which residents used because no shops had been provided on the estate. Respiratory illnesses were aggravated by ducted warm air heating and the practice of drying clothes indoors (because of inadequate facilities.) Another study of families living in flats found that depression in isolated women and serious accidents among children were both linked to the design of the building.[183]

The Housing and Environmental Health Departments of the Wirral, Merseyside, identified serious design and construction faults in their high-density housing.[184] Water penetration, ventilation, heating and insulation problems, inadequate under-floor electric heating, deck access and high child densities "combined to produce disaster." These faults resulted in dangerous and severly limiting conditions for the tenants including lack of privacy, lack of playing facilities, noise, lack of clothes drying facilities, dependence on lifts, inadequate refuse disposal, and the obvious safety aspects of the height of buildings.

Burr et al (1981)[185] in a study in South Wales, suggest that respiratory symptoms may be agravated by damp housing and by open coal fires which were thought to cause some pollution of the air inside the house. See also Burr (1986)[186c]

Hunt et al[186a] found clear effects of damp housing on the health of children in a deprived area of Edinburgh in 1986. In particular, respiratory/bronchial symptoms, headaches and diarrhoea were much more common among children living in damp housing. The effect of damp was indepentent of the effect of low income or smoking in the household. Strachan[186b] in a 1984

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

An in-depth study of 107 women living with pre-school children in Milton Keynes in 1984[192] found that 51% of lone-parents and 30% of low-income 2-parent mothers were cutting down on food consumption for financial reasons. 67% of low-income women found it difficult to afford what they considered to be a healthy diet for their children.

It is commonly found in such studies that food is treated as a flexible item in the household budget (unlike rent and rates) and when money is short, food spending tends to get cut back. Unfortunately the cheaper foods are often the ones higher in fat and sugar.

A number of "desk-top calculations" have been carried out to estimate the cost of following advice on a "healthy diet," to see if recommendations are realistic for people on low-incomes. One, looking at the cost of an "adequate" diet in pregnancy, concluded that the cost may be beyond the means of families dependent on benefits or low wages.[193] For example, an average couple living on supplementary benefit in 1984 spent 9-10% of their income (excluding housing) on one person's food. However, it was estimated an "adequate" diet for a pregnant woman would have taken up 28% of the couple's income.

The British Dietetic Association[194] has considered the dietary problems of special groups at risk of malnutrition - children, pregnant women, ethnic minorities, the handicapped and elderly - and concluded that existing benefits for some members of these groups were insufficient for their dietary needs.

One recent study[195] basing the 'healthy diet' on N.A.C.N.E.,[196] calculated that the recommended diet could cost up to 35% more than the typical diet of a low-income family. Some would dispute the figure of 35% and suggest that community studies are now needed to check how valid these calculations are in real-life settings.

In recent years an increasing number of studies have gone out into the community to do just that: to document how people in different circumstances live and how they cope with aspects of health. In the field of family health care, Graham[197] has collected and reviewed over 250 studies relevant to the question "how do parents meet their responsibility to family health?" The following paragraphs draw heavily on her work.

It has been noted that all household resources have the potential to influence health - income, housing, fuel, food and transport. The pattern of spending on these basics varies between rich and poor families. For example, in 1985 poor households spent 56% of income on necessities (food, fuel, housing) whereas rich households spent 36% of their income on these products[198]. While 95% of professional households have at least one car available, only 38% of unskilled manual households have one.[28] It is found that the poorest families may have little choice of fuel, and often have to rely on the most expensive kind.[200] Families who are economising on fuel risk making their homes cold,

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

study in Edinburgh also found an association between respiratory problems in children, reported by their parents, and damp or mouldy housing. However, such environmental factors were not linked to G.P. consultation rates for these illnesses. This highlights the dilemma of which measure of morbidity to use in community studies. These and other issues are fully discussed in the papers from a recent conference on unhealth housing.(186a-e)

6.5.2 Income

There have been few studies in this country on the direct effect of income on health, partly because of the enormous difficulties encountered and partly because of political sensitivity. To be meaningful, all sources of income would have to be assessed, including the value of fringe benefits, property etc. and such statistics are not readily available in this country. A preliminary analysis has been carried out by Wilkinson (1986)(187) on occupational incomes and mortality in 22 occupations, comparing 1951 and 1971. Over the 20 years those occupations which had increased their income relative to average earnings tended to experience a relative decrease in mortality rates. In occupations where income had gone down relative to the mean, mortality rates tended to go up relative to the mean. The death rates of old people also seemed to vary in a similar way with changes in the real value of state pensions over the years from 1965-82. As Wilkinson notes, this work will have to be repeated and extended before firm conclusions can be drawn.

Another study(188) has looked at the effect of income, but this time on children's height. A study of families in poor areas in London in 1973-76 found that a low amount of money spent on food/person/week in a household was highly correlated with poor growth in the children. Amongst these children protein intake was 92% of the recommended daily intake, iron 80% and vitamin D 40% of that recommended. 11% of the children in the survey were mildly or moderately malnourished.

The indirect effect of income on health, for example on choice of diet and eating habits, has been more widely investigated. As outlined on page 65 people from low-income households tend to eat less fruit, vegetables and high fibre foods, and more fat and sugar than people from high income households.(189)

Studies of why this should be so have found lack of money to be a major factor restricting food choice as well as limiting the quantity of food consumed. For example, a study of 65 families living on supplementary benefit in 1980(190) found that some parents went without food to provide enough for their children, and lack of money was frequently cited as the reason for lack of fruit and vegetables in the diet.

In a study of 1,000 low-income people in the North of England in 1984(191) approximately a quarter of respondents reported that they did not have a main meal every day. One third of these said this was because of cost. Four out of ten unemployed people went without a main meal because of lack of money.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

damp and prone to condensation. Even within families, there is evidence of resources not being shared out equally. For example, parents may go without food to provide for the children, and the adult breadwinner may be given more food than those who stay at home. If a family has a car it cannot be assumed that women and children have access to it for food shopping and health appointments during the day. Frequently it is found that the male breadwinner in a household has priority over use of the car for work. The issue of transport has been growing in importance as food outlets and medical services become centralised. The time and money spent on travelling becomes a factor to be considered in health service use. One study of pregnany women found that women going to the hospital antenatal clinic spent twice as long travelling and waiting than mothers going to local G.P. clinics. They also experienced great problems travelling with young children.(201)

Several studies examine how mothers cope with the stress of caring for the family on a low-income, which often involves a juggling act of keeping within a very limited budget while at the same time keeping the children well and relatively contented. There is evidence that mothers find a variety of ways of relieving stress in the short-term without leaving the child alone. Graham(197) points out that this often leads to parents going against medical advice. Sweets tend to be used as quick and easy ways of keeping children quiet on shopping trips and on other stressful occasions,(202) breast-feeding may be abandoned to allow more time for other members of the family,(203) and babies' milk may be mixed with cereal to help cope with crying and sleep problems.(204)

Cigarette smoking was used by some mothers as a way of easing tension without leaving the room.(205) Jacobson has also recently highlighted the use of smoking by women to help them survive their stressful workload.(206)

Graham(197) points out that such actions, which would be labelled irresponsible by some professionals, may be the only way in which mothers can stay sane and act responsibly towards their family.

Poor attendance for preventive health services is also examined in terms of costs and benefits. Graham concludes:

> "For poor families in particular a rational decision may be one which rejects professional care. The mother may choose instead to invest her limited resources of time, money, and energy in other areas of family health" - in food for the family for example, or in keeping her children warm.(197)

These studies on family health, in particular, indicate a complex relationship between individual behaviour and structural and material fators. When researchers start to ask "why" behaviour does differ between classes, it becomes clear that socio-ecnomic circumstances do play an important part.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

6.6 Explaining sex differences in health

Parallels can be drawn between the explanations of social class inequalities and those of sex inequalities in health. The artefact, natural selection, behavioural/cultural and materialist/structuralist explanations have all been applied to sex differentials.

Some of the sex differences in morbidity (with high rates for women) for instance, have been attributed to artefact, though the exact extent of this is unknown. Morbidity may be underestimated for men relative to women due to more proxy reporting for men in surveys; or women may have a greater predisposition to report illness. Additionally women may be more inclined to take care of their own health, resulting in increased consultation rates or days of restricted activity for the same amount of illness.(207) All these points need further investigation and, of course, none of them can explain away the sex differential in mortality.

The natural selection or genetic explanation, suggests that women's greater longevity and low mortality rate is an intrinsic feature of the human species. This view is supported by the fact that even before birth female foetuses have better survival rates than male foetuses.(77)

Whatever the merits of the genetic explanation, evidence that the sex differential in mortality is reversed in less developed countries (like Napal and Bangladesh), and that even the morbidity differential is not a fixed phenomenon in the same country, suggests that the social and cultural environment and health services can play a powerful part in modifying the differential. If that is so, then there should be scope for improvement in health for both sexes.

Very little work has been published on the causes of the sex differential in Britain, though studies in the United States and Europe attempt to answer the question: "Why do women live longer than men?" See Waldron(207) and Haavio-Mannila(85) for reviews.

Waldron(132) notes that male mortality exceeds female mortality by 100% for seven of the major causes of death in the United States: coronary heart disease, lung cancer, emphysema, motor-vehicle and other accidents, cirrhosis of the liver and suicide. These causes account for 75% of the sex differential in mortality in the United States. Reasons for the differential have been analysed at the behavioural/cultural level. Waldron(132) estimated, for example that well over half the difference between male and female death rates could be accounted for by behaviour differences e.g. - cigarette smoking, alcohol consumption and occupational hazard. She concluded that sex differences in behaviour are more important causes of higher male mortality than genetic factors.(132)

Haavio-Mannila(85) compared sex differentials in health and illness in Sweden, Denmark, Finland and Norway and found great variation in the morbidity differential. For example, the sex differential in symptoms of anxiety was much smaller in Finland

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and Sweden than in Denmark and Norway. Type of employment also had and effect on the differential. She found excess female morbidity in agricultural and manual workers. In white-collar groups, students and pensioners however, men and women had similar standards of health. In some countries, like Finland and Norway, white collar women were healthier than their male counterparts. Overall, the excess female morbidity rate was mainly due to higher rates for female manual workers and full-time housewives.

In general Haavio-Mannila(85) concluded that in countries where many women work outside the home, the sex ratio in illness and hospitalisation rates are lower for women. In countries, and at period of time in the same country, when women mostly stay at home, women's morbidity rates are high. Arber et al(61) found employment outside the home to be a benefit to some groups of women and a burden to others, depending on their social circumstances.

Leviatan and Cohen (1985)(208) were interested in the causes of the difference in life expectancy between men and women. They argued that if much of the difference between males and females was due to environmental factors, then there may be situations where the difference could be reduced. They hypothesised that Kibbutz life might be capable of narrowing the gender gap in life expectancy by providing a closely matched environment for men and women with less difference in gender roles than in other developed countries. Calculating the expected gap in life expectancy from international data, they found that in the Kibbutz the observed gap was much smaller - at birth the gap was 4.5 years instead of the expected 7.1 years, and at age 50 the gap was 2.7 years instead of the expected 5.1 years. The gap had been reduced by improvements in male life expectancy rather than by a reduction in female life expectancy.

These recent studies open up intriguing possibilities for improvements in the sex differentials in health, though investigations are only at a preliminary stage. They certainly illustrate the potential importance of social and environmental factors on the health of both men and women.

6.7 Conclusions

The four possible explanations of inequalities in health put forward by the Black Working Party have been reviewed in the light of new evidence. From the evidence, the inequalities between social groups are genuine and cannot be explained away as artefact. Further evidence has confirmed the existence of a health selection effect - in particular, showing that serious illness in childhood can cause a fall in occupational class later on. There is also renewed evidence of selection for height at marriage. Estimates suggest that the selection effect is small and does not account for the much larger differentials in health observed.

The weight of evidence continues to point to explanations which suggest that socio-economic circumstances play the major part in

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subsequent health. The evidence that health-damaging behaviour is more common in lower social groups continues to accumulate especially concerning smoking and diet. There is also a growing body of evidence that material and structural factors like housing and income can affect health. Most importantly, several studies have shown how material and structural factors can limit the choice of life-style and it is this set of studies which illustrates most clearly that behaviour cannot be separated from its social context. Certain living and working conditions appear to impose severe restrictions on an individual's ability to choose a healthy life-style.

The evidence suggests that policies to reduce inequalities which focused entirely on the individual would be misguided. The importance of social and material factors highlighted by the research suggests that broader policies incorporating structural improvements in living and working conditions would be required.

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SECTION 7

THE RESEARCH RESPONSE

7.1 Assessment of the Black Report

As soon as it was published the Black Report attracted great interest within the research community.[209,210] It was accepted as an authoritative document and rekindled debate on inequalities in health.[277,121] Brotherston commented "It is a mine of information and will merit study for many years to come."[211] Individual researchers put forward criticisms of details of the report.[212,215] For example some felt that the discussion on explanations of inequality could have gone into the theoretical concepts in much greater breadth and depth.[215,13,169] However, even its critics acknowledged that its main findings were sound and paid tribute to the contribution it had made to the literature in this field.

> "No-one reading the report could easily contradict the conclusion from the weight of evidence it assembles that systematic class-related differences in health experience do exist; that these are associated with the structure and operation of the socio-economic system within which people are born, live and die; and that a way out of these inequalities will involve very much more than individual responses: the government is inextricably involved"
>
> Gray (1981)[215]

Several bodies responded by setting up meetings to discuss the implications of the recommendations of the Report for future research and policy. These included the Faculty of Community Medicine,[211] the Social Science Research Council[297] and VOLCUF.[298]

There was general agreement on the major problems hindering further research, which the Black Report had identified, and these are discussed below.

7.2 Data collection

In 1980, the Black Working Party found that statistics on many important issues were not collected routinely or were missing altogether. For all concerned this greatly hampered the task of planning and evaluating policies to reduce inequalities in health. Consequently the Working Party considered that it would be easier to trace and assess continuing inequalities:

- if school health statistics routinely recorded the height, weight, hearing and other health indicators of school children in relation to occupational class;
- if statistics on accidents to children routinely recorded the circumstances of the accident, and the age and social class of the parents;
- if the National Food Survey were adapted to be a more effective measure of nutritional status, and be able to identify "at risk" groups in the population;

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

- if the General Household Survey developed a more comprehensive measure of income and command over resources, so that the influence of poverty/affluence could be related to self-reported illness in the survey.

It also recommended that the problems of social inequalities in health and their causes should be officially adopted as an area of further research by the DHSS, in association with the MRC and SSRC, and co-ordinated centrally.

None of the four recommendations on data collection has been adopted in the intervening six years, so policy-makers still have to rely on special surveys carried out from time to time at national or local level. Nor have the major research-funding bodies adopted the subject of social inequalities in health as a priority issue for co-ordinated action. Furthermore it has become even more difficult to obtain information on social class and health even from the traditionally available sources. The Black Working Party drew heavily on detailed analyses from the occupational mortality supplements of the Registrar General's Office produced around each census. However, the latest supplement published in 1986[17] did not carry out such analysis of the data, and several researchers have expressed their frustration at this latest obstacle to research.[216,120]

Despite this rather negative picture at national level, and the difficulties encountered, there have been notable developments in this field, including the following examples.

7.3 Post-coding

Social indicators from the Census Small Area Statistics (S.A.S.) are now readily available on tape from OPCS, down to the level of wards. From this, over 250 variables are available for analysis, including housing and over-crowding factors, consumer durable ownership, employment status, family composition and so on. Since 1981 (1974 in Scotland) OPCS has provided post-coded death records, and also post-coded birth records. Since 1982 birthweight has been recorded almost universally on birth and perinatal death certificates.[87] In Scotland all in-patient statistics and cancer registration have been post-coded since 1975.[90]

This opens up much wider opportunities for analysing small areas, below the level of local authority or health district. For instance, it makes it much easier to pin-point areas of poor health and to explore which social and other factors in those areas are implicated. In this context the Black Report called for further research "on the development of area social conditions and health indicators for use in resource allocation" and "the study of the interaction of the social factors implicated in ill-health over time, and within small areas." Numerous studies of this kind have been undertaken by health and local authorities in direct response to the Black Report, making use of this newly available data. These studies have already been outlined in Table 5 (pages 28 - 29) but in the following section some of the technical considerations will be discussed.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

7.4 Developing measures of social inequality

Small area analysis does have some unique problems which have been reviewed by Carstairs (1981).[90] In particular small areas produce small numbers of events e.g. only a handful of deaths/year. To compensate for small numbers results have sometimes been aggregated over several years. Alternatively results for areas with simlar social profiles have been combined. OPCS sponsored a series of studies in the 1970's to find ways of identifying and grouping together wards with similar socio-economic composition irrespective of where they were in the country.[43,44] For example, in the Craig-Webber clasification 40 variables from the census data have been employed to group census wards together to form 36 socially distinct "clusters". Clusters range from "high status suburban areas" to "poor quality housing in areas of economic decline", and this classification has been used in other studies - for example Fox et al.[45] (see page 18). A Classification of Residential Neighbourhoods (ACORN) is a similar approach which has been developed commercially, based on the age structure of an area, together with its employment level, family composition, type of housing, car ownership and social status. Only the post-code is required to identify the social profile of a neighbourhood. The value of using the ACORN system in health studies is being investigated.[217,218]

Other studies have combined several indicators of social and material deprivation into a composite deprivation index. Areas can then be ranked by their degree of disadvantage or affluence acording to their score on the index. The question of which social indicators to include in the index is crucial and warrants closer inspection. See Thunhurst (1985)[219] and Townsend et al (1986)[220] for reviews and discussion of indices. Table 17 shows the social indicators used to define deprivation in 6 area-based studies.

It should be noted that some indices combine direct indicators of deprivation, like overcrowding and unemployment, with indirect measures of the number of people at risk of deprivation e.g. the proportion of one-parent families, or elderly people or ethnic minorities in an area. The problem is not all people in such groups are deprived. Mixing up material conditions and "at risk" groups like this can result in certain pitfalls.

For example Townsend et al[220] point out that the Department of the Environment's index[225] finds that the 10 most deprived local authority areas in England are all in London, with none in the North. Similarly the Jarman Index[221] finds 7 of the 10 most deprived health districts are in London and none in the Northern Region: figures which fly in the face of other observations. Thunhurst[219] points out that such results are obtained when an index is dominated by certain highly skewed variables such as ethnic minority households and one-parent family households which are more highly concentrated in the inner London boroughs than elsewhere. If no correction is made for this skewed distribution then high scoring areas on the index may simply be high scoring areas for ethnic minority or single parent households.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Thunhurst[219] points to ways of overcoming this problem, for example by the use of more sophisticated statistical techniques and by using 'grass-roots' surveys to check and extend the statistical results.

Townsend et al[87] solve the problem by choosing only indicators of material deprivation such as the proportion of households with no car, or with electricity disconnected or with an unemployed head. Likewise social class is not included in the composite index, but is analysed separately so that the inter-relationship between health, deprivation and social class can be investigated.

Table 17

A comparison of the social indicators used in six area-based studies

Jarman Underprivileged Area Score[221] (see also 222, 223)

(G.P.'s identified factors thought to influence their workload). Score based on 10 social variables selected from census following G.P. survey:

% children under 5
% unemployment
poor housing factor
% ethnic minorities
% single parent households
% elderly living alone
overcrowding factor
% lower social classes
% highly mobile people
% non-married couple families
(indicating less stable family groups)

Scott-Samuel Score[224]

Census variables used to construct composite measure incorporating the proportion of people in an area not in employment due to permanent sickness, combined with 10 social factors:

persons aged over 15 with temporary sickness;
households overcrowded;
households severely over-crowded;
households owner-occupied;
households rented from local authority;
households with no car;
men aged 16-64 out of employment;
women aged 16-59 out of employment;
private households with 3 or more dependent children;
one parent families

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Table 17 (cont.)

Thunhurst "Areas of Poverty" (Sheffield)(93)

18 variables used:

unemployed men, women and young people;
one-parent families;
overcrowded households (more than 1.5 persons/room)
social class IV and V households;
proportion of households lacking bath and/or W.C.
proportion of households with 6 or more persons;
proportion of households lacking a car;
proportion of population aged 0-15 years;
proportion of population aged over 60/65;
proportion of population in households with head of New Commonwealth or Pakistan origin;
proportion of in-migrants during the previous year;
proportion of households renting council accommodation;
proportion of persons aged 18-24 being students;
proportion of households renting furnished accommodation;
proportion of households renting unfurnished accommodation;
Analysis supplemented by 'Grass-roots' survey of health and social service professionals in the city.

Department of Environment Score (1983)(225)

Indicators of urban deprivation:

% unemployed persons
% overcrowded households
% single-parent households
% households lacking exclusive use of basic amenities
% pensioners living alone
% population change
Standardised Mortality Ratio
% residents living in households where head of household was born in the New Commonwealth or Pakistan.

Townsend et al - Indicators of social and material disadvantage (Bristol)(94)

from census data	(Households with fewer rooms than persons (Households lacking a car (Economically active persons seeking work (or temporarily sick)
from locally collected data	(children aged 5-15 who receive school meals free (households experiencing disconnection of electricity

Townsend et al - Combined Deprivation Indicator (Northern Region)(87)

% of economically active residents aged 16-59/64 who are unemployed;
% of private households which do not possess a car;
% of private households which are not owner occupied;
% of private households with more than one person per room.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

7.5 Measuring social class

Although occupational class has traditionally been used to measure social class it is not without its problems particularly in relation to women.(226) In mortality statistics and studies on morbidity (in the General Household Survey for instance) married women have often been classified by their husband's occupational class and single women by their own occupation. At least three major problems arise:

(a) 52% of married women now work outside the home either full-time or part-time. Classifying them by their husbands occupation may conceal health hazards linked to their own employment.

(b) It may also conceal differences in health between married women who are housewives, those who are unemployed and those who are in paid employment.

(c) The earnings of working women may well influence the standard of living and material resources of the household, but this is not taken into account if the husband's occupation alone is used.

Difficulties with the unemployed, the elderly and children also arise. For these groups occupational class may not fully encapsulate the circumstances under which they live.

Several alternative approaches have been suggested and are being investigated. For instance Arber(84) suggests that the most appropriate measure would be household class, rather than individual class, based on the occupation of the spouse who is economically dominant. Groups can also be differentiated by their assets e.g. house and car ownership, and the OPCS Longitudinal Study has done extensive work on this.(22)

In relation to children, one alternative measure is the Social Index(12) developed for use in the Child Health and Education Cohort Study and intended to be more in tune with the home environment of the child than occupational class alone. This incorporates seven socio-economic variables associated with the child's environment:

occupational status of head of household
parents education
social rating of neighbourhood
tenure
crowding index (persons/room)
bathroom availability
type of accommodation

If any one variable, like occupational class, is not available, a score can still be obtained for the family by adjusting the index accordingly. The Social Index provides a continuous scale running from the most disadvantaged to the most advantaged social groups, and appears to be more sensitive to social inequalities in childhood than the Registrar General's social class scale. For example, it has identified disadvantaged groups experiencing difficulties in health service use which were not detected by the use of occupational class.(12)

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

7.6 Developing measures of health inequality

From the Black Report there was also the recommendation that policy decisions on, for example, resource allocation should not be based on area mortality data alone.

There are calls for the use of morbidity data and measures of positive health, like height and weight, in area studies in addition to mortality rates. With the advent of post-coded birth records containing birthweights, the incidence of low birthweight in small areas can now be used as a health indicator in such studies. Townsend et al[87] for example have used it in their study of health inequalities in the Northern Region and the Greater Glasgow Health Board used it in their review of deprivation and ill-health in the city of Glasgow.[92]

Another promising tool for surveying health problems and evaluating service provision is the Nottingham Health Profile.[10,31] It defines, much more specifically, than say the General Household Survey, the nature of health problems in the population and the impact of those problems on everyday activities. The Profile is in two parts. Part I assesses health in six problem areas considered to be important by the lay population i.e. pain, energy, physical mobility, sleep, social isolation and emotional reaction. Part II measures the effect of these health problems on paid employment, ability to perform jobs around the house, and the effect on relationships, sexuality and so on. Each section carries a score of 100 - the higher the score the greater the number of problems experienced. The Profile has been shown to relate well to more traditional measures such as the presence of chronic illness and the seeking of medical care, but it provides an added insight for policy-making. Studies using this profile have been described in Section 2.

Blaxter[33] has reviewed the many different measures commonly used as health indicators in inequality studies and has been experimenting with 5 measures of health to assess their usefulness for future large-scale surveys. The five dimensions are: disease, functional disability, "illness" or frequent symptoms, "malaise" (lack of psychological well-being) and fitness. The problems of measuring health are considered in depth in this study.

The Health and Lifestyle Survey,[34] a national sample study of 9,000 people, is beginning to provide data on a whole range of health factors which have not been available on a national scale before. As well as collecting data on illness symptoms and conditions in the sample, the survey has taken physiological measurements, and collected information on life-style factors, self-assessment of health, orientation towards healthy behaviour, and can relate these to a variety of socio-economic parameters including income.

The Welsh Heart Health Survey[227,295] of 1985 (to be repeated in 1990) is also providing valuable data in the realm of positive health. 20,000 people in the nine health authorities in Wales were interviewed to provide a baseline of health indicator and life-style factors against which to assess health promotion activities.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

One of the issues highlighted for further research by the Black Working Party was in the field of disability and handicap. The Working Party called for prevalence studies of disability in the community, which made assessments of the severity of disablement e.g. by self-care criteria. They also wanted studies on the interaction of processes leading to physical and mental handicap and disadvantage, and how some children escape the effects of disadvantaged conditions. The Child Health and Education Study based on a cohort of children born in 1970, has been engaged in studies of this nature. One of its aims has been to investigate the extent of disability and learning difficulties in the national sample of 10-year-old children. To do this it has been developing a measure of disability based on an inventory of skills and behaviour. With the inventory the parents of each child in the sample can make an assessment of the child's ability; and norms for the population can be derived. Results from groups of disabled children can then be compared with the norms. In addition it is making assessments of educational achievement, undertaking medical examinations to assess physical health, and collecting information on a range of social and environmental factors associated with each child. From the data it may be possible to map the development of disability and learning difficulties and assess the importance of the factors involved.(228)

7.7 Conclusions

The Black Working Party highlighted major deficiencies in data collection and six years later these deficiencies have still not been remedied. Improvements have been made in some fields, for example in the production of statistics for use on a small area basis, but the inherent problem spreads far beyond research on inequalities in health to encompass public health research in general. The Australian 'Better Health' Commission(229) has recently confirmed a similar situation existing in Australia and outlines a number of pre-requisites for public health research including: the need to develop a comprehensive and accessible data base of national health statistics; the need to find methods of widely disseminating statistical information and ensuring that it is understood by the public; and the need to establish administrative structures and appropriate funding strategies, which will guarantee funds over a long period.

Many argue that a first and most important step towards improved health statistics would be a regular National Health Survey similar to that conducted in Canada, to provide the necessary data base. This would benefit not only research in social inequalities but the whole field of public health and prevention. Also of considerable potential help would be the inclusion of health questions in the census.

Despite the shortcomings in data collection there has been an upsurge in research on social inequalities in health, as the numerous studies reported in earlier sections testify. It is significant that many of these studies were directly stimulated by the publication of the Black Report.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

SECTION 8

THE HEALTH AND SOCIAL SERVICE RESPONSE

This section considers what action health and social services have taken to reduce inequalities in health and what is still to be done.

The policy put forward by the Black Report had three main thrusts:

- priority for children to give them a better start in life;
- priority for disabled people, who carry the greatest burden of ill-health in the community, to improve their quality of life and help them stay independent;
- priority for preventive and educational action to encourage good health.

Each one will be examined in turn.

8.1 Giving children a better start in life

Recommendations concerning child health included a shift in the resources of the NHS and social services towards community care, particularly antenatal, post-natal and child health services; improvement in the facilities and accessibility of antenatal and child health clinics; greatly expanded nursery school and day-care provision for the under 5's; and a revitalised school health service linked in an effective way to general practice to intensify surveillance and follow-up. Such a strategy, it suggested, would give some support to parents while mitigating some of the effects of a poor environmment for many young children, as well as improving the identification and treatment of children most at risk.

In general, the response to these recommendations has been disappointing. Although there is a concensus that a shift towards community care is desirable, it has not been translated into a comprehensive commitment. Events in the child health services over the past 10 years have been thoroughly reviewed by the National Childrens Bureau.(36) A survey of district health authorities in 1986 enquiring about budgets for child health services, found that these services were treated differently in each district. There was no underlying strategy linking the development of the services throughout the country. In fact, some districts could not separate out resources given to child health services from the rest of the budget, which made it difficult to evaluate progress.(230)

With re-organisation of the NHS in 1982 the posts of area medical and nursing officers responsible for child health disappeared. There is no longer an obligation to nominate a senior member of staff to have responsibility for child health and it is feared that co-ordination of the service has suffered as a result.(36) The delivery of the preventive child health services also seems to vary greatly around the country. A survey in 1983 found that some

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

districts ran 500% more child health clinics than others. Service provision was not related to any obvious criterion of need in the community.(36)

Small, but increasing numbers of general practitioners are running their own pre-school child health clinics. As for the school health service there is great concern that the quality of the service has actually declined(36) or is not fulfilling its full potential.(231, 232) The administration of the service varies greatly from one district to the next. In the light of this, all major professional bodies concerned in the field have been urging properly co-ordinated integrated services for children.(233, 234) A review of services has found that most of the recommendations of the Court Report of 1976 have still not been implemented.(36) The National Children's Bureau has made recommendations on how the surveillance and preventive procedures for children could be organised at a District level, co-ordinated by a designated person, eg. a consultant community paediatrician.(36)

Local authority provision of day-care for children under 5 is still over-stretched and concentrated on the most deprived groups. There has been no move to extend the service to a wider section of the community, as envisaged in the Black Report.

Although the overall picture on services for children is patchy there have been outstanding efforts in certain areas, especially in relation to the Black recommendation:

> "that districts should review the accessibility and facilities of all antenatal and child-health clinics in their areas, and develop plans to increase utilisation by mothers."

This recommendation has been taken seriously by many groups around the country, and services in the antenatal care field in particular have improved enormously. Dowling (1983)(235) has made a comprehensive review of new developments in preventive health care in pregnancy and early childhood and documented over 60 schemes operating in England and Wales, which have tried to ensure that services reach those who need them. New initiatives are continually being evolved. To give a few examples, in Nottingham an experimental programme has been investigating the organisation of a child health clinic serving a deprived population.(236) A community paediatric team approach has been used and has resulted in attracting older, more deprived pre-school children, and the detection of more treatable medical disorders. In the same city a scheme has been developed to identify infants at high risk and support them with additional health visiting.(237)

In Oldham, the District Health Authority, through its "Healthy Parents/Healthy Babies" project(238) is looking at how a district can provide comprehensive antenatal care for the population, making sure it responds to the needs of those living in deprived or poorly-served areas. This project includes provision of services in the workplace.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

In the primary care setting, a group of general practitioners has been exploring ways of improving preventive care for deprived patients, with various out-reach programmes and schemes for tracing and responding to missed care through patients' records.(146)

8.2 Improving the quality of life for disabled people

The recommendations in this field were aimed mainly at improving the care of elderly and disabled people in their own homes. The strategy involved reviewing hospital, residential and domiciliary care for the disabled elderly, reviewing sheltered housing provision, encouraging joint care programmes and increasing community support especially in the form of nursing services for disabled people and home-help services with greatly extended functions.

The British Medical Association in an excellent review of services for the elderly in 1986(239), pointed out that 95% of elderly do still live in their own homes and should receive community support, but they are "often abandoned, with wholly indadequate social services support."

There is no evidence of a substantial shift in resources to community care for the disabled and elderly in the 1980s. A recent Audit Commission Report (1986)(240) found that:

> "Although there has been worthwhile progress in some areas, and most authorities have at least made a start, care in the community is far from being a reality in many places."(240)

What has been significant is the rapid expansion of private residential and nursing homes since 1983. In that year the DHSS for the first time allowed local authority social service departments to make payments to private residential homes to place frail elderly people. Homes have been springing up all over the country and DHSS payments to them in 1983 totalled £102 million,(239) rising to £200 million in 1984 and over £500 million in 1986.(240) The BMA points out that this large expenditure on private residential homes conflicts with the government's stated policy of redirecting resources to community care. There is also the fear that elderly people may be pressurised into accepting places in nursing homes when they could continue in their own homes if they had adequate support.(239) The Audit Commission also detailed conflicting funding policies by the DHSS which had prevented the setting up of the very community services which the Department had been advocating.

The level of district nurse, health visitor and home-help provision is far from adequate. For instance, the 1976 DHSS recommendation of 12 home-helps/1,000 elderly people(241) has still not been accomplished, even in the best-served areas. The Centre for Policy on Aging reviewed local authority provision for the elderly in 1984 and found continuing deficiencies.(242)

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

There has been a promising development in relation to the role of home-helps, though. Several social service departments have recognised that home-helps can do much more valuable work on behalf of disabled people, as recommended by Black, and have extended their functions accordingly. For example in Cheshire the home-help service is being replaced totally by a "home-care" service. Home-care assistants are being trained in the care of elderly and disabled people and employed on a similar basis to care assistants in residential homes.(243) Provision of this service is still not at an optimum level.

Sheltered housing is another valuable service which can help disabled and elderly people retain a measure of independence. Evidence suggests that there is growing inequality of opportunity to take advantage of sheltered housing. There is a thriving market in the private sector where over 10,000 units/year are being built by private developers in 300 schemes around the country. However, in the public sector, building of sheltered homes has come to a virtual standstill and this obviously affects mostly council and private tenants who cannot afford to buy their own property.(239)

It would be wrong to give the impression that nothing was being done in this field. Currently there are a number of experiments attempting to improve the quality of life of elderly and disabled people, particularly those who do need residential care. The aim of several of these projects is to give residents as much independence as possible, with their own furniture and possessions around them and more privacy, but with nursing facilities on site if and when required.

In a new approach to community care, boroughs like Camden have introduced foster care schemes for the elderly and disabled. Volunteers are paid to take disabled people into their own homes and care for them on a long-term basis.(239)

The HEC and Age Concern's "Age Well" programme has since 1984 been encouraging and disseminating information on initiatives which promote independence in old age, especially ones organised by the elderly themselves.(246) In Scotland, the Scottish Health Education Group has an on-going in-service training programme for a variety of professionals and para-professionals with the aim of de-medicalising the care of the elderly and encouraging independence. The aim is to make helpers aware of when they are creating dependence in the people they care for and help them reverse the process.(247)

There is no doubt, however, that the need for community support services is undiminished. The BMA report recommends the urgent development of respite care to help the carers of disabled and elderly people, as well as greater provision of home-help services, telephone alarms, laundry services, meals-on-wheels and so on - all services which allow disabled people to remain in their own homes.(239)

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

The Audit Commission made recommendations for immediate action on funding and managerial policies. The Commission warned that if action is not taken: "The result will be continued waste of scarce resources and worse still, care and support that is either lacking entirely, or inappropriate to the needs of some of the most disadvantaged members of society and the relatives who seek to care for them."(240)

8.3 Priority for preventive and educational action

The recommendations under this heading were mainly concerned with action the government could take in the field of prevention and education to encourage good health. These included:

* the setting of national health goals;
* an enlarged programme of health education with particular focus on schools;
* stronger measures to reduce cigarette smoking;
* specific screening programmes;
* and the funding of a series of intensive health and social development programmes in 10 disadvantaged areas on an experimental basis.

(It should be noted that preventive strategy has expanded considerably since 1980 and would now encompass a much wider range of policy options than those envisaged in the Black Report).

There have been attempts to draw up detailed national health goals for the UK(248) but this particualr recommendation has now been superceded by this country's adoption of the World Health organisation's 38 "Targets for health for all by the year 2000."(5) What is now needed is wider publicity for and discussion on these targets with all the agencies involved in their implementation. As a discussion opener the Faculty of Community Medicine has published its proposals on action to be taken in this country on the WHO targets.(249) In the absence of a national initiative by government an independent committee under King's Fund/Health Education Council/London School of Hygiene auspices is to report on the issue in 1987.(250)

The question of whether an "enlarged programme of health education" (recommendation 20) has been funded is a difficult one to answer. More money has certainly been provided for specific emergency topics like drugs and AIDS education, but the amount provided for more comprehensive health education programmes, which might start to tackle the issue of inequality, has not noticeably been increased. For example the budget of the Health Education Council for the past 10 years had remained at roughly 0.1% of NHS hospital expenditure. In April 1987 the Council is to be incorporated into a special "Health Education Authority" with additional responsibility for AIDS educaton, so resources for general health education may change completely.

Despite past limitations on funding, health education has developed considerably particularly in the school sector. For an assessment of achievements in this field over the past decade see Whitehead (1987).(251)

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

Measure taken to reduce cigarette smoking have been piecemeal and progress, though evident, linked mainly to higher social classes. For example, while tobacco advertising and sales promotions are still very much with us, the 1986 voluntary agreement has banned such advertising from cinemas and certain women's magazines.(252) Current negotiations on sports and arts sponsorship between the tobacco companies and the government may at last lead to restrictions, but in the meantime, both BBC and ITV have imposed their own house rules to reduce exposure of tobacco companies logos etc. in sponsored sporting events.(253) Although it has not become official government policy, taxes on cigarettes have gone up by about 30% in the last 5 years, and in the last budget the Chancellor acknowledged that the latest price rise was in response to the health lobby.(252) The health warning is still on the side of the cigarette pack rather than on the front, but the size has been enlarged and the wording varied to try to create more impact.(252)

It is in local authorities where noticeable initiatives on smoking in public places have taken place. A 1985 survey by ASH(254) found that 83% of local authorities had smoking bans or restrictions in council meetings (compared with 78% in 1983). Almost 20% of councils also had smoking restrictions in their offices and staff canteens. 16% had banned tobacco promotion on council owned poster sites.

Screening for neural tube defects and Down's syndrome, as recommended in the Black Report, is now generally available. Screening for hypertension in adults is not so widespread, though there are major community projects incorporating BP screening in Wales,(227) Oxford(256) and Glasgow.(257)

The intensive health and social development programmes in selected deprived areas, envisaged in the Black Report, have not been funded, but there have been several smaller-scale initiatives. For a review of projects using a community development approach see the King's Fund Report.(258) The HEC has been funding a series of community development experiments over the past 5 years. For example the Mansfield Community Health Project(259) has, since 1982, been developing ways of reaching in particular young mothers and isolated elderly people in the community. The Catford Project(260) (1982-85) was located in an inner-city deprived area and explored the feasibility of a community health council employing a health worker to help local people identify and act on their own health needs. The Paddington and North Kensington District Health Authority has been developing a model for health authority action in a deprived inner city area.(261)

A few district health authorities, like Cambridge, have built in action on inequalities in health into their strategic plans for the next ten years. Cambridge, for instance, has selected for priority the low paid, one parent families, the unemployed, the overcrowded, disabled, ethnic minorities and lone pensioners.(262) A survey of all Regional Health Authorities in England was carried out in 1986 to analyse the Regional strategies and policies for promoting

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

health and preventing disease and this will provide an overview of the long-term plans of the health service in this field.(263)

On the issue of unemployment, a research study has been looking at ways of helping health and social service professionals respond to deprivation. So far it has examined the implications of unemployment for the training and practice of health visitors, social workers and health education officers. The next phase will develop and test training materials for these professionals.(264)

On a larger scale, major projects based in Wales(227) and Glasgow(257) are developing community strategies for tackling one aspect of health - coronary heart disease prevention. Although focussed only on one subject the strategies are wide-ranging and cover not only education directed at individuals, but also the provision of services, facilities and structures which improve the environment. As such they may act as models for future co-operative action among the many health and social service professionals involved.

The issue of ethnic minorities and health sevices has been attracting more attention in recent years. Johnson(265) discusses why the medical profession has been slow to recognise this new client group. Donaldson and Odell(266) carried out a survey in 1984 of District Health Authority services catering for the special needs of the Asian population. Many authorities were attempting to provide services, despite the lack of an adequate information base. Improvements in national data collection were suggested to help DHAs.

The National Extension College, with the DHSS and HEC, has been developing training and training materials for health workers.(267-269) The College has also carried out a survey of training needs on health and race, to identify priority topics in their area.(270)

Schofield(271) gives a sensitive insight into the obstacles and mental health problems faced by Asian-born women living in the UK, and offers guidance for health service personnel.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

SECTION 9

RESPONSE TO THE WIDER STRATEGY

As material and social factors were seen as playing a major role in maintaining inequalities in health, a broad social policy was proposed by the Black Working Party, through four main strategies. First and foremost: "the abolition of child poverty should be adopted as a national goal for the 1980s" achieved through various means involving:

increases in child benefit and maternity grants;
the introduction of an infant care allowance;
attention to nutrition of children, particularly in school meals which should be free for all;
increased pre-school education and childcare.

Secondly the Working Party recommended improvements in housing and working conditions.

Thirdly they proposed a fairer deal for disabled people, both through comprehensive disablement allowances and through special funding for housing adaptations and services.

Fourthly a co-ordinated government policy was envisaged, involving national and local government and an overseeing Health Development Council responsible for planning and monitoring progress of the policy.

So what has happened? What has been the response to this strategy? The following sectoins bring together some of the evidence on the present situation and on initiatives which have been taken.

9.1 The Government Response

The initial response of the Government to the recommendations of the Black Working Party has been well documented.(2,272,273) All the recommendatons were rejected as too expensive, costed by government economists at £2 billion. Those which would have cost very little appear to have been overlooked in the overall rejection. Doubt was also cast on the existence of some inequalities in health. This was in contrast to the assessment made by the research community, which accepted the Report as a sound and authoritative document. (see page 78)

Consequently, a co-ordinated policy to reduce inequalities in health in the UK has not been adopted. "Greater co-ordination between government departments in the administration of health related policies - by establishing inter-departmental machinery in the cabinet office" (recommendation 36) is still very much required. Local counterparts of this national structure have not been encouraged, nor has an over-seeing Health Development Council been set up.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

On the other hand, the government has committed the UK to the WHO 'targets for health for all', one of which is the reducton of inequalities in health between groups in this country, (see page 7). This could signal a renewed commitment to solving the problems of health inequality.

9.2 Abolishing child poverty?

The goal of abolishing child poverty is nowhere in sight. In fact, the situatioin has become worse in recent years as more families with young children have fallen into the low-income category. For example, in 1971 22% of the poorest fifth of the population consisted of families with children, but by 1982 the figure had risen to 30%.(274)

If poverty is defined as income marginally above the level of supplementary benefit, then in 1981 over 3½ million children in the UK were living in poverty[275] - a quarter of the nation's children! Half of these children came from working families on low incomes, half from families where the head was unemployed. The rise in child poverty has mainly been attributed to the rise in unemployment which has affected people with young families more than others.(276) The situation continues to deteriorate. By 1983 the Child Poverty Action Group estimated that one third of all children in Britain were living in families in or on the margins of poverty.(276)

In 1983 400,000 children were living in extreme poverty, below the supplementary benefit line. Coupled with those on the SB level, this represents a doubling of the numbers since 1973.[276]

The experience of poverty has been felt by an increasing proportion of the population as Table 18 illustrates. In 1979 a total of 11.5 million people (22% of the population) were experiencing poverty, in 1981 the figure had increased to over 14 million (27.5% of the population) and by 1983 it had increased again to 16.3 million (30.5% of the populaton).(216) During that period other indicators of deprivation also showed similar increases. For example, the number of homeless people increased from 41,000 in 1979 to 140,000 in 1984(277), with an estimated 9,000 families in England now living in bed and breakfast accommodation -an unsafe and disadvantaged environment for children.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

TABLE 18

Changes in Extent of Poverty 1960-1983 (Britain)

Income in relation to supplementary benefit standard	1960[a]	1975	1979	1981	1983
	Number in thousands				
Below SB standard	1,260	1,840	2,090	2,610	2,700
Receiving SB[b]	2,670	3,710	3,980	4,840	6,130
At or up to 40 per cent above SB standard	3,510	6,990	5,500	7,210	7,550
TOTAL	7,440	12,540	11,570	14,660	16,380
	Percentage				
Below SB standard	2.3	3.5	4.0	4.9	5.0
Receiving SB[b]	4.9	7.0	7.6	9.1	11.4
At or up to 40 per cent above SB standard	6.4	13.2	10.4	13.5	14.1
TOTAL	14.2	23.7	22.0	27.5	30.5

Notes: a The 1969 data are for the U.K. and are on a household rather than an income unit basis. It should be noted that the estimates are based on national assistance scales, not supplementary benefit scales.

b Drawn separately from supplementary benefit sample enquiry with people drawing benefit for less than 3 months excluded. Thus people unemployed or sick or disabled for less than 3 months are counted as having the incomes they had last in employment.

Source: Townsend, P. (1986) see reference 216, derived from the following sources: for 1960, B. Abel-Smith and P. Townsend, The Poor and the Poorest, 1965 pp. 40 and 44. The data are drawn from the FES of that year. For subsequent years, DHSS analyses of the FES. The most recent of these, covering 1983 and revised estimates for 1979 and 1981, was placed in the House of Commons Library on 27 July 1986.

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Conversely, as more people have fallen into poverty in the 1980s, the rich appear to be getting richer, after decades of a gradual closing of the wealth gap. According to Inland Revenue statistics,(278a) the share of marketable wealth (including houses, stocks and shares etc.) owned by the richest 1% of the population had been dropping steadily since the war until 1980. In that year the richest 1% owned 20% of the total wealth. In 1981 their share increased slightly to 21% where it stayed until 1984. Likewise the richest 5%'s share of wealth, which had been dropping steadily, has stabilised at 39% of total wealth since 1980. Trends in the distribution of income between 1976 and 1984 also reflect growing inequality.(299) This has been attributed to several factors including a boom in the stock market, the easing of certain capital taxes, and cuts in income taxes linked with substantially bigger increases in gross pay for those on high incomes.(278b) All these factors have particularly

Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

benifited those who were already wealthy, while doing little to help those who were poor. The measures recommended by the Working Party which might have helped to reduce poverty, like substantial increases in child benefit and an infant care allowance, have not been implemented. Halsey,(300) in a review of social trends in the United Kingdom, points to a growing social division since the mid-1970s between the prosperous majority and the poor minority.

On other fronts the situation has also worsened, for example in relation to the nutrition of children. The school meal service, for instance, envisaged by Black as a source of free, nutritionally sound meals for all children, is in jeopardy in many local authorities. Fees have had to be increased, the nutritional standards were abolished in 1980, many have introduced self-service fast-food arrangements, and financial constraints mean that in some areas the service may disappear altogether.

9.3 Improvements in housing and working conditions?

The hoped-for improvements in housing conditions have not materialised. Two key factors give cause for concern - the shortage of houses and the poor state of repair of existing houses. In 1977 it was estimated that 200,000 dwellings/year were needed throughout the 1980s. In reality there has been a severe drop in building to the level of 40,000 dwellings/year in the public sector, with the private sector unable to make up the difference.(279) Shelter has estimated that the public sector has experienced a 60% cut in investment since 1979, so efforts have had to be concentrated on the repair of existing stock rather than new building programmes. However, the housing stock is in a poor condition. In addition home improvement grants have dropped to a very low level since 1982. In 1981 the Parker Morris Standard for council housing was suspended and a substantial proportion of houses built since then, at least in the Greater London area, have fallen below that standard.(279) These developments go directly against the Black recommendation that local authority spending on housing improvements should be substantially increased.

Working conditions are also causing concern. One report found that there had been a 23.6% increase in serious industrial accidents in the 1980's in the U.K. suggesting that safety standards for those in employment may be deterioating.(281) While there is no evidence of a concerted effort by government, employers and unions to develop acceptable and desirable conditions at work, or even to monitor conditions more effectively, some industries have been leading the way. A review of health promotion activities in the worplace in 1986(280) found that over half of Britain's workers (and 80% of workplaces) had no access to even basic occupational health services other than first aid. However, the survey did find that some of the major public and private sector employers and leading trades unions had begun to develop programmes for prevention and health promotion among the workforce. The survey noted a change in emphasis between 1976 and 1986, with occupational disease reduction now seen as just as important as accident prevention, and in the last year or two much more attention given to health promotion. As well as giving examples of good practice from the survey, this Study(280) is valuable in recommending targets for health at work for the year 2000, and in outlining the action needed to develop a comprehensive workplace health service.

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Source: https://www.industrydocuments.ucsf.edu/docs/xkhl0000

9.4 Putting inequalities in health in the agenda

Although there is no unifying national lead on the issue, nevertheless, what has been done by individuals and organisations in the context of policy-making should not go unrecorded.

As noted in Section 2 page 27, many local authorities and health authorities have carried out their own 'local Black Reports' to help with resource allocation and service planning. These were directly inspired by the findings of the original Black Report. The Association of Metropolitan Authorities is currently attempting to co-ordinate the data base needed to describe indicators of poverty and health in cities for further small area analyses.(282)

At least 20 local authorities have set up health committees (distinct from Environmental Health Committees) to co-ordinate local strategies. Six have also appointed health liaison officers to make communication easier with the various departments and organisations across the full range of services in the community. It has been pointed out that such figures do not give a complete picture of the work going on in local authorities. Many long-established Environmental Health Departments for example are making valuable contributions in this field. What is urgently required is a review of initiatives around the country which could be disseminated widely.(282)

Some cities are well ahead in their planning for health promotion. The City of Oxford, for example, has adopted a "City Health Strategy"(283) including in its aims "to offset health inequalities related to social class, gender, ethnic origin, age and disability" and "to secure and sustain a safe and healthy environment within the City". It is carrying out a health audit of all Council policies and activities.

The ambitious World Health Organisation "Healthy Cities"(284) project, which began in 1986, is focusing on how cities can promote health. The aim is to develop in 10-12 European cities, a broadly-based approach to health promotion in partnership with the people in those cities, which could act as a model for other cities across Europe. This project will encompass aspects of both deprivation and affluence found in the city environment.

Several organisations have been working out detailed policies and action required from their own particular perspective. All these initiatives help to put inequalities in health on the wider community agenda. For example, the Unemployment and Health Study Group has produced policy guidelines(49) on the issue of unemployment, including consideration of how the health and social service professions can help reduce morbidity associated with unemployment. The British Medical Association in direct response to the Black Report, has a current working party considering deprivation and ill-health, which should shortly be producing recommendations for acton both for the medical profession and in the field of public health in general.(285)

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The Scottish Health Educaton Co-ordinating Committee convened a Working Party on multiple deprivation which has reviewed projects and action on the issue taking place throughout Scotland and has made recommendations for wide-ranging acton.(286) Two major conferences on the issue have been organised in Glasgow (1986) and Edinburgh (June 1978).

The Archbishop of Canterbury's Urban Priority Areas report "Faith in the City", published in 1985(287) forcefully focused public attention on the plight of the inner cities and made wide-ranging recommendations for effective action. The recommendations were reinforced in November 1986 when the Church of England announced that it was providing £10 million for action to help the inner cities.

An important document reviewing the promotion of health in the UK over the past 10 years, puts forward a comprehensive strategy for health promotion under 4 main headings : environments for health, life-styles for health, preventive services for health, and organisation and resources for health. One of the chief themes of this strategy is reduction in health inequality.(250)

The Health Education Council has been organising conferences on deprivation and ill-health and on the community development response to deprivation, in an attempt to inform and motivate professional action on the subject.(288) In 1986 a new organisation, the Public Health Alliance, was formed to bring together individuals from the health, local government, voluntary and consumer sectors with the aim of making sure that the public health aspect is given priority on a wide range of national issues. These range from poverty and food policy to housing and transport. If such an organisation can raise the awareness of policy-makers to such issues, then there is a greater chance that recommendations on reducing inequalities in health will at last be taken seriously.(289) One of the policies that this and the other organisations have been advocating strongly is a National food and nutrition policy,(290) (291), along the lines of that adopted by Norway.(292)

Finally it is worth looking at what has been happening to public attitudes to social inequalities. From survey evidence there appears to be a softening of attitudes to poverty by the general public, with the poor now attracting greater sympathy. For instance, a Gallup poll in 1977 found that 33% of people blamed the poor for their own plight. In 1986 the same question was asked and this time only 17% blamed the poor, while 53% blamed "circumstances beyond their control."(293) In 1984 a Mori poll found that 74% of people thought that the gap between the rich and the poor was too wide and there was widespread support for increased benefits, even at the cost of higher taxation.(294) Perhaps the community at large would now appreciate more than ever concerted acton on inequalities in health.

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